S
362.196
9703
Montana
1992

MONTANA RESPONDS TO HIV/AIDS:

A FIVE-YEAR PLAN

October, 1992

AIDS/STD Program
Montana Department of Health
& Environmental Sciences
and the
Montana Area Health Education
Center

Draft 11/12/92

STATE DOCUMENTS COLLECTION

APR 1 ° 1993

MONTANA STATE LIBRARY
1515 E. 6th AVE.
HELENA, MONTANA 59620

PLEASE RETURN

MONTANA STATE LIBRARY
S 362.1969792 H2mrhad 1992 c.1
Montana responds to HIV/AIDS :a five-yea
3 0864 00082315 6

Montana AIDS

Introduction 1

Summary of Plan Recommendations 4

Dimensions of HIV/AIDS in Montana (to be added) 10

Preventing the Spread of HIV/AIDS 10
HIV and the General Public 12
HIV and Montana's Youth 20
Culturally Diverse Populations 27

Assuring Treatment and Support Services
for People with HIV/AIDS 33

Building Leadership in the Fight against AIDS 39
Public Sector Leadership 39
Private Sector Leadership 41

Preserving Human Rights and Dignities 45
Non-Discrimination 46
Decriminalization of Homosexuality 49
Confidentiality and the Need to Know 51
HIV Reporting 53

Appendices
Prevention Programs and Services 58
Office of Public Instruction Activities 63
Services for Individuals with HIV/AIDS 65
Planning Advisory Council Membershi 69

Digitized by the Internet Archive
in 2010 with funding from
Montana State Library

http://www.archive.org/details/montanarespondst1992mont

Introduction

Why This Plan Was Written

Since the first case of AIDS was reported in Montana in 1985, many programs and activities have been initiated to try to stem the spread of HIV and to assure that needed services are available for those who are infected with the human immunodeficiency virus. Until now, however, there has not been a plan which sets forth in one place what these activities should be and how they should be configured.

The need for a comprehensive response to the epidemic was recognized several years ago by the statewide AIDS Advisory Council which was advising the Montana Department of Health and Environmental Sciences (MDHES) on AIDS issues at the time. In 1991 the MDHES AIDS Program applied for, and received, funding from the Health Resources and Services Administration, a federal agency, for the purpose of preparing a five-year plan. These funds, supplemented with funds from the Montana Area Health Education Center and the MDHES AIDS program, were used to contract with a consultant to assist in developing this State HIV/AIDS Plan.

What The Plan Covers

The Plan opens with a discussion of the dimensions of the HIV/AIDS epidemic in Montana, presenting information about how many people have contracted AIDS in the State, what the modes of transmission have been, and what the demographic characteristics of those with AIDS have been. Projections of how many are infected with HIV (but have not developed AIDS) in the State are made and an estimate of how many persons with AIDS Montana might anticipate seeing in the next three to five years is offered.

Following this review of facts and figures is a chapter on prevention and education. Because the incidence of AIDS in Montana is low relative to that in most other parts of the country, Montana is presented with an opportunity others do not have -- to keep the numbers low. But whom should education and prevention activities target? And what barriers are there to a successful prevention program and how should these be addressed? These issues are dealt with in this section.

The Plan follows with a section which looks at treatment and support services needed by persons with HIV/AIDS, where gaps in these exist, and how these should be eliminated.

Another section discusses the essential attributes and actions needed in the less tangible areas concerning leadership and infrastructure if HIV/AIDS is to be dealt with effectively in

Montana.

A final section of the Plan examines statewide policy issues which must be addressed if Montana is to have an effective response to the AIDS epidemic.

Each of the sections carries recommendations. Readers will note that the actions called for in the Plan are the responsibility of many and diverse players. It was intended to be -- and is -- a Plan which says what needs to be said in the view of those involved in the planning effort and is not merely a Plan for State government or the State AIDS Program.

How The Plan Was Developed

The development of this Plan involved both top down, meeting with individuals who develop policies and shape programs, and bottom-up approaches, meeting with those affected and/or working at the community level. Development of the Plan was initiated by the MDHES AIDS Program with funding it procured. The first step was to appoint a Planning Advisory Council representing a broad range of perspectives concerned with the epidemic (see page 69 for list of Advisory Council membership). The Advisory Council then assisted in the selection of the consultant, oversaw the planning process and made decisions about the Plan's contents.

The consultant traveled throughout the State gathering input from more than 100 Montanans about HIV/AIDS in Montana and how it should be addressed. Information was collected through individual interviews and public meetings in several cities. Those providing input included persons infected with the virus; their families and friends; health care professionals including physicians, nurses, home health and hospice workers; volunteers in community based AIDS organizations and involved in other ways; county health department personnel; staff from chemical dependency programs; staff working with urban and reservation Indian populations; staff working with migrants; school administrators, teachers, parents, and students; staff of State entitlement programs, the Human Rights Commission, and the like; and others representing a variety of perspectives.
All the information gathered through this process was sorted and sifted through and organized into issue papers which the Planning Advisory Council discussed. And, during these deliberations, the Plan's recommendations were formulated.

How The Plan Is To Be Used

It is the hope that all who are involved with HIV/AIDS in Montana will use this Plan as their guide as they develop programs, seek funding, and/or draft legislation or position papers related to AIDS over the next several years. An equal, if not more, important hope for the Plan, however, is that it will cause each resident of Montana to reexamine his/her attitudes about the epidemic and to become involved in whatever way possible to prevent the spread of the disease and to promote humane and sensitive treatment of those who are infected with HIV/AIDS.

The completed plan will be presented to the Director of the Department of Health and Environmental Sciences (MDHES). The Director will submit the plan to the Governor.

Dissemination Of The Plan

Copies of this Plan have been distributed to those involved in the planning process, HIV/AIDS related activities, and to all public, college and university libraries in Montana. Copies of the executive summary and the complete plan many be obtained by calling the MDHES AIDS/STD Program at (406) 444-3565 or by writing to that Program at the following address: MDHES AIDS/STD Program, P.O Box 20091, Helena, Montana 59620.

Next Steps

One of the recommendations in this Plan calls on the Governor to appoint a council which will oversee the implementation of recommendations in the Plan and develop a process whereby the Plan will be reviewed and updated regularly. Such updates are particularly important given the rapidly changing and evergrowing HIV/AIDS epidemic.

Summary Of Plan Recommendations

This Plan contains thirty recommendations aimed at preventing the spread of HIV/AIDS, providing treatment and support services for those who are infected with the AIDS virus, building leadership in the fight against AIDS, and preserving human rights and dignity through the promotion of sound state policies. The justification for each of the recommendations may be found in the pertinent Plan section. This summary is meant to provide a ready reference to all the recommendations in the Plan by bringing them together in one place.

Recommendations for Preventing The Spread Of HIV/AIDS

HIV/AIDS And The General Public

1. Additional public funding shall be sought to enable the nine Health Education and Risk Reduction (HERR) sites in the State to reach larger audiences with messages about the transmission of HIV and how to avoid it, and to develop and offer educational programs aimed at changing attitudes, such as homophobia, which impede an effective response to the AIDS epidemic. Efforts should be made to maximize available federal funding for support of the HERR sites. State funding should be sought to complement the federal funds. Within three years, the HERR sites should be receiving twice the funding they were allocated in 1991.

2. The MDHES AIDS Program shall provide specialized training to staffs at HERR sites to enable them to address homophobia in the communities with which they work.

3. Additional public funding shall be sought to support the eleven Counseling, Testing, Referral and Partner Notification (CTRPN) sites to enable them to meet the ever increasing demand for HIV testing. In addition to the federal funding which is made available for this purpose, county governments in Montana should work with the local health departments which operate the CTRPN sites to assure that funding is adequate. Since counseling and testing through CTRPN sites is not available in all counties, financial arrangements should be made for those counties without sites to help finance the CTRPN site within whose catchment area they fall.

4. Private funding shall be sought to support the educational activities of the AIDS Community Based Organizations (CBOs) located in the State. Private businesses, individuals, and religious bodies in Montana should be looked to for most of the funds needed by the CBOs. A parent organization should

assume responsibility for coordinating state-level fundraising activities of the CBOs and provide technical assistance for community-level fundraising by the CBOs. The MDHES AIDS Program shall nurture the development of any organization acting in this role.

5. Public and private funding for special projects aimed at HIV/AIDS education for the general population should be maximized.

HIV/AIDS And Montana's Youth

1. HIV/AIDS education shall be available in grades K-12 in every public school in Montana. Further, the basic information which must be taught in each grade, as already identified by OPI, shall be made part of a comprehensive school health curriculum by specifically including HIV/AIDS education in the Health Enhancement Section of the Montana School Accredition Standards.

2. The Office of Public Instruction's program to train teachers to offer HIV/AIDS training to teachers should be continued.

3. Institutions of higher education in Montana which prepare primary and secondary school teachers should add as a requirement for graduation a class on HIV/AIDS and its transmission and a methods course on teaching youth about this and how to avoid contracting the disease.

4. MDHES, LOCAL HEALTH DEPARTMENTS, LOCAL SCHOOL DISTRICTS and OPI should jointly support the formation of local, school-district-based, teen peer group organizations which could advise the district on matters related to HIV/AIDS education in the schools, serve as a sounding board for their fellow students concerning matters related to HIV/AIDS, and encourage health-promoting behaviors among their peers.

HIV/AIDS And Special Populations

A. Persons Who Practice High Risk Behaviors

1. The MDHES AIDS Program shall continue to fund HIV/AIDS education activities targeted toward gay and bisexual men who continue to practice unprotected sex. Additional funds should be sought to expand these activities.

2. The MDHES AIDS Program shall work with the chemical dependency treatment agencies in the State to develop HIV/AIDS prevention/education projects which target IV

drug users and others who abuse alcohol and drugs. The goal should be to develop a program in one geographic area in the State each year. The planning and funding of such activities should be joint efforts between the state agencies and private entities involved.

3. The MDHES AIDS Program shall work with the community based organizations in the State to develop HIV/AIDS prevention/education projects which target women at risk for heterosexual transmission of HIV. The goal should be to develop a program in one geographic area in the State each year. The planning and funding of such activities should be joint efforts between the state agencies and private entities involved.

B. Culturally Diverse Populations

1. More resources should be found to support HIV/AIDS prevention/ education activities directed toward Montana's minority populations.

2. The Montana Minority AIDS Task Force shall coordinate the activities of various groups which are working to educate Montana's minority populations about HIV/AIDS and shall assist MDHES in ongoing planning aimed at identifying program gaps and designing approaches to deal with these. MDHES should identify funding which will allow the Montana Minority AIDS Task Force to carry out these responsibilities.

Building Leadership In The Fight Against AIDS

A. RECOMMENDATIONS REGARDING PUBLIC SECTOR ENTITIES

1. The GOVERNOR should constitute and support an HIV/AIDS Council, per 2-15-122 MCA, charged with overseeing the implementation of this Plan and establishing and administering an ongoing planning process to address the epidemic. The Commission shall include representatives from communities affected by HIV/AIDS and from agencies and organizations working to prevent the spread of HIV and serving those infected with the AIDS virus. The Commission should be adequately staffed and funded to carry out its important assignment.

2. The MDHES AIDS PROGRAM shall take a leadership position in promoting sound public health policy as it relates to HIV/AIDS and its containment. Among the ways it should exercise this leadership are the following:

* developing standards for HIV/AIDS programs operating in the State and providing technical and community organizing assistance for local communities as they devise their strategies to prevent the spread of HIV and to serve those with HIV/AIDS (this should include sponsoring opportunities for networking among like workers and volunteers in the communities, such as case managers or pre/post HIV test counselors);
* continuing and expanding its role as a source of funding to combat the AIDS epidemic;
* challenging the status quo wherever this is detrimental to the public's health; and
* initiating an Interagency AIDS Work Group comprised of State employees and aimed at fostering communication and coordination among State programs which deal with aspects of HIV/AIDS and between these programs and other state-level organizations in the private sector and non-state, public agencies (such as IHS and the VA).

3. The STATE DEPARTMENT OF LABOR AND INDUSTRY should take a leadership role in educating employers in Montana about the legal rights of employers and employees when employees have HIV/AIDS, about how situations involving workers with HIV and/or AIDS can be handled sensitively, and what the issues are regarding continuing health care benefits for employees with HIV/AIDS. The Department should have available model employer/employee HIV/AIDS policies which businesses in Montana can use as they begin to develop such policies.

4. The HEALTH PROFESSIONS LICENSING BOARDS within the STATE DEPARTMENT OF COMMERCE should aggressively enforce compliance with non-discrimination of persons with HIV/AIDS among their licensees.

5. The MDHES HEALTH FACILITIES DIVISION should aggressively enforce compliance with non-discrimination of persons with HIV/AIDS among their licensees.

6. LOCAL HEALTH DEPARTMENTS shall continue serving as the lead agency in Montana's counties/communities in responding to the AIDS epidemic. Their activities should be aimed at:

   * preventing the spread of AIDS (including providing education to the community, offering HIV counseling and testing, and carrying out partner notification);
   * carrying out local surveillance and policy development activities; and

* assuring that needed services are available for persons with HIV/AIDS (including maintaining a working relationship with others providing AIDS education and support services such as community-based organizations).

7. The INDIAN HEALTH SERVICE should coordinate its AIDS prevention and service activities with those of other public sector entities and the private sector and should engage in joint planning activities with these groups. In this way resources can be maximized and Native Americans can be assured continuity of programs and services regardless of where they are residing in the State or what their tribal affiliation is.

B. RECOMMENDATIONS REGARDING PRIVATE SECTOR ENTITIES

1. The MONTANA ASSOCIATION OF CHURCHES should develop a position paper on HIV/AIDS and those infected covering the following points:

- AIDS is a disease and should be treated as such.
- All need to be compassionate and humane toward those with HIV/AIDS.
- Churches should strive to promote the worth and dignity of those infected.
- All churches are encouraged to become involved with local task forces or community based organizations, to make meeting rooms available for support groups, to assist in raising money for community-based organizations' emergency funds/housing support, etc., and in developing educational efforts for their congregations and the larger communities in which they are located.

2. The MONTANA MEDICAL ASSOCIATION, the MONTANA OSTEOPATHIC ASSOCIATION, the MONTANA DENTAL ASSOCIATION, THE MONTANA NURSES ASSOCIATION, and other professional and voluntary health associations should provide leadership in the following ways:

* assuring that their members know it is illegal to discriminate against persons with HIV/AIDS by denying access to care and helping to police their own in this regard;
* providing educational opportunities on HIV/AIDS for their members;
* formalizing networks between primary care providers and specialists who are experts on HIV/AIDS, in Montana and elsewhere;
* fielding complaints from community-based organizations and health departments when members

are perceived to be creating barriers for persons with HIV/AIDS to get served;

* advertising State programs (such as the MDHES Early Intervention Program, HIV Care Consortia, Insurance Continuum Program and the AIDS Drug Reimbursement Program) to their members; and
* working with MDHES to get AIDS cases reported and assuring that their memberships understand the public health implications of accurate and timely reporting.

3. The MONTANA FUNERAL DIRECTORS ASSOCIATION should promote the willingness of its members to bury or cremate the bodies of persons who have died of an AIDS-related disease.

4. The MONTANA HOSPITAL ASSOCIATION, working with INFECTION CONTROL PRACTITIONERS and OCCUPATIONAL HEALTH PRACTITIONERS, MDHES, and the HIV/AIDS Advisory Council to be created under these recommendations, should examine the need for modifications to State law regarding the requirements for pre- and post-test counseling and for obtaining informed consent when accidental exposures to bodily fluids occur in health care facilities. Any modifications should stress both the rights of the source person and of the person possibly exposed. Any modifications should complement OSHA's standards regarding bloodborne pathogens. The procedures should strike a balance between responding to the very real fears of the persons exposed and not overreacting to the extremely small risk that any health care worker will contract HIV during exposure situations.

Preserving Human Rights And Dignity

A. Non-Discrimination

The present State statutes prohibiting discrimination against persons with HIV/AIDS should be preserved and enforced.

Resources should be found to enable the Montana Human Rights Commission and other agencies responsible for responding to alleged HIV-related discrimination to expedite the investigation of complaints from persons with life-threatening illnesses so that a resolution of the complaint may be reached while claimants are still living. Further, identities of persons filing charges should be kept confidential, except as release of information is required by law, and people should be informed that they may file complaints with the Human Rights Commission anonymously.

B. Decriminalization of Homosexuality

The portion of Montana's Sexual Crimes Act which makes sexual activities between consenting adults illegal should be repealed.

C. Confidentiality And The Need To Know

Montana's statutes regarding confidentiality and the "need to know" should be clarified so that all understand that instances which permit identifying information to be released regarding an individuals HIV status are rare. MDHES shall develop policies addressing this issue and assist health professional organizations in the education of their membership.

D. HIV Reporting Requirements

Reporting of HIV status by name or unique identifier should not be required of providers at this time. However, the State AIDS Program shall more aggressively pursue the collection of demographic and transmission information on HIV+ patients from physicians submitting samples to the state lab for testing.

Dimensions of HIV/AIDS in Montana- to be added by MDHES

This section will not contain recommendations or policy statements. it will serve to present much of the data the AIDS Program has collected regarding the HIV epidemic and will be inserted in the final plan.

Preventing the Spread of HIV/AIDS

The pages which follow address several priority populations toward which HIV/AIDS prevention and education activities in Montana need to be directed over the next three to five years. These are:

* **the general public** because it holds attitudes and beliefs which are not conducive to the promotion of the public's health and the prevention of the spread of HIV;

* **school-age youth** because we must protect the health of the future generation of Montanans and youth are at an age when experimentation and risk-taking are common;

* special populations including a) **persons who practice behaviors which put them at high risk for contracting HIV** for obvious reasons, and b) **culturally diverse populations including Native Americans and Hispanics** because of cultural issues which need to be taken into account to assure that they protect themselves against HIV.

HIV/AIDS AND THE GENERAL PUBLIC

Montana's Challenge

Montana's geographic expanse, sparse population, and low incidence of HIV/AIDS combine to present a formidable challenge to designing an effective statewide response to HIV/AIDS. Somewhere among the nearly 800,000 persons in Montana (799,065 actual population per 1990 census), and scattered across a land mass 570 miles from east to west and 340 miles from north to south, are the 137 persons (as of October 31, 1992) who have full-blown AIDS and the estimated 600 to 900 others who are infected with HIV but who have not yet developed one of the conditions which defines their status as AIDS. Some of these persons know they are infected, but most probably do not.

On the one hand Montana's low incidence of HIV/AIDS presents the state with an opportunity to intervene before the disease spreads further in the population -- an opportunity not available to other states where the infection is much more widespread in the population (see map below). On the other hand, because so few are currently infected and many Montanans do not think they know anyone who is HIV positive, there is an incredible amount of denial that AIDS has come to Montana and will affect "me and mine". As a result many people do not listen as carefully as they should to messages about how the virus is transmitted and how to avoid it and do not take the necessary precautions to protect themselves from transmission.

Furthermore, Montana's vast distances place an extra burden on its prevention activities and require resources to "get the word out" about HIV/AIDS beyond what is needed in jurisdictions which are smaller in size or which are more densely populated. Finally, because most Montanans have had so little experience with the

disease, AIDS has become a specter toward which people react irrationally and, when in the presence of someone with AIDS, frequently quite callously.

The degree to which Montanans are misinformed about HIV/AIDS is reflected in the responses to the Behavioral Risk Factor Surveillance System (BRFSS). The BRFSS reflects the responses of more than 1000 Montanans who were surveyed in 1990 and 1991 regarding their knowledge, attitudes, and beliefs about AIDS. In both years more than one in five of those queried said they would not be willing to work with a person infected with the AIDS virus. In 1990 more than half (52.4%) said they would not eat in a restaurant where the cook is infected with the AIDS virus, but in 1991 this jumped to more than three in five (65.3%) who were unwilling. Likewise, in 1990 just under one in four (23.9%) responded that they think you can get infected with the AIDS virus from giving blood while in 1991 nearly two in five (39.7%) thought this to be true.

Real-life examples of overreactions to AIDS which have occurred recently in Montana include these:

> A person with AIDS bakes brownies and takes them to hospital workers to thank them for the nice treatment received when he was in the hospital. The brownies remain uneaten and are eventually thrown out.
>
> A youngster refuses to go into a room where someone with AIDS has been earlier that week.

Patients in a physician's office move to another waiting room when they see one of his AIDS patients waiting to see the doctor.

A school board is unwilling to allow a person with HIV in the school to talk to students.

(All of these situations occurred in mid- to large-size cities in the State. This is to say, these problems are not peculiar to only Montana's very rural areas.)

It should be noted that, while it is important in a plan to focus on the gaps, problems, and issues which must be addressed to mount an effective response, there are many persons in the State -- in places large and small -- who <u>are</u> informed about HIV/AIDS and how it is and is not transmitted, who <u>are</u> sensitive to the needs of those infected with HIV, and who are contributing their time and energy to do whatever they can to address the needs. Without the work of these "unsung heroes" Montana would have an even greater distance to go to address the epidemic than it now has.

Attitudes

Beyond these basic hindrances to mounting an effective response to the AIDS epidemic in Montana, however, are other attitudes held by a number of Montanans which further impede prevention efforts.

The first of these is <u>homophobia.</u> Simply defined, homophobia is the fear of homosexuals or homosexuality. Though individuality and a live-and-let-live mindset have historically been valued in Montana, this tolerance does not seem to extend to diversity where sexual orientation is concerned. The law making consensual sex between persons of the same sex a felony punishable by one of the stiffest prison sentences and highest fines in the country is only the most tangible manifestation of this. More insidious, and hence more difficult to address, however, is the homophobic behavior regularly expressed by many Montanans when occasions trigger it.

A detailed study, titled Survey of Homosexual and Bisexual Population- Acquired Immune Deficiency Syndrome, was conducted for the Montana AIDS/STD Program in 1990. The survey dealt with a variety of HIV/AIDS related issues and was sent to individuals on the mailing list of a statewide organization called Out in Montana (OIM). As an organization concerned with the rights of homosexuals and AIDS issues, OIM's mailing list provided a convenient means of disseminating the survey. Based on the survey results, those identifying themselves as homosexual or bi-sexual have experienced discrimination as a result of their sexual preference in a variety of settings. Those types of discrimi-

nation most frequently encounter include verbal harassment, reported by 36% of respondents, and rejection by family and friends, reported by 18%.

Other anecdotal examples of homophobia include these.

> Some ministers, when approached by volunteers to see if they were willing to provide spiritual counseling if and when anyone with HIV/AIDS needed it, respond that they would but it would be incumbent upon them to tell homosexuals that they are sinners and would need to repent and change their behavior.
>
> A group of teens beat up a gay youth.
>
> A newspaper carries a one-line notice of a meeting of gays and lesbians, precipitating numerous complaints and letters to the editor to which the editor responds with an editorial saying the paper should be free to print notices of any group which is meeting.

(Though the particular examples given here occurred in some of Montana's mid-sized and smaller communities, it is likely that similar examples could be found in towns of other sizes around the State.)

The problem that homophobia creates for preventing the spread of HIV is that it drives underground many of those whose behavior puts them and their sexual partners at risk for contracting the virus (since the predominant mode of transmission in Montana as well as in most of the rest of the United States continues to be unprotected sex between men). As a result they are hard to find

to deliver educational messages to, and many are reluctant to come forward for counseling and testing to learn whether they are infected with HIV.

Closely connected to the issue of homophobia is people's discomfort with issues concerning sexuality. The problem created as a result of this discomfort is that it makes it difficult to talk clearly and precisely about sexual modes of transmission -- including which sexual activities put one at more or less risk -- and how to protect oneself. It further leads to denial among parents that their children are sexually active, and hence that they need to hear messages about how HIV is spread and how to avoid it.

Examples of where dis-ease about sexuality have hampered communications which need to take place are these.

> A newspaper in Montana says a factual list of ways HIV can be transmitted in a paid ad submitted by a local health department to encourage those at risk for HIV getting tested, is too explicit, and the health department has to delete these from its ad.
>
> A line drawing of a penis is censored out of material about puberty used in a school presentation.

To date the primary entities which have had formal responsibility for HIV/AIDS prevention/education activities in Montana have been the MDHES AIDS/STD Program which provides statewide leadership in this area and passes through federal dollars for AIDS education activities; the nine designated Health Education and Risk Reduction (HERR) sites which receive these federal dollars to carry out prevention/education activities in their areas; the eleven designated Counseling, Testing, Referral, Partner Notification (CTRPN) sites which provide anonymous HIV testing and pre- and post-test counseling and related services; the nine, largely volunteer, community based organizations (CBOs) which receive some HERR funds as well as raising some private funds to undertake educational activities; counties without HERR sites which were eligible for receipt of funds from Preventive Health Services Block Grants (app. $425 per county) in state fiscal year 1992 and 1993; and several organizations with which the MDHES has contracts for prevention activities which target specific populations. The following recommendations relate to these entities. More information about their funding and other important facts may be found in Attachment X.

Recommendations:

Given that the attitudes described here which inhibit effective prevention of HIV/AIDS are pervasive throughout Montana, it is essential that educational activities aimed at changing these

bedirected toward the general population. Since denial and ignorance are complex issues, ongoing and multifaceted approaches will be required to address them. Clearly, a message delivered once about HIV/AIDS and how to avoid it will not be sufficient. Further, it is essential that truths about the disease be faced head-on. While understanding people's sensitivities about some of the issues related to the AIDS epidemic, in the long-run it will be more important to talk openly and frankly about how the disease is transmitted and how to avoid it than to remain polite and risk misinforming people about a disease which is preventable but which, if contracted, will kill them. The following priority recommendations are made with regard to educating the general population.

1. **Additional public funding shall be sought to enable the nine Health Education and Risk Reduction (HERR) sites in the State to reach larger audiences with messages about the transmission of HIV and how to avoid it, and to develop and offer educational programs aimed at changing attitudes, such as homophobia, which impede an effective response to the AIDS epidemic. Efforts should be made to maximize available federal funding for support of the HERR sites. State funding should be sought to complement the federal funds. Within three years, the HERR sites should be receiving twice the funding they were allocated in 1991.**

   Explanation: The nine sites in the State which are currently funded by the Centers for Disease Control through the MDHES AIDS Program to carry out health education and risk reduction are grossly underfunded to do the job they need to do. (See Attachment X for information about the HERR program.) With a total allocation of $68,320 for 1991, there is simply not enough money to mount an effective educational campaign about HIV/AIDS across the State. During the 1991 legislative session, approximately $425 of the Preventive Health and Health Services block grant was allocated to each county without an HERR program. The federal funds provided through the block grants will again be available in state fiscal year 1993 to those counties interested in using this funding.

   Although the state of Montana pays for all or part of the medical costs of individuals receiving public assistance (e.g. general assistance and Medicaid), Montana is one of the few states in the nation which has not dedicated state funds directly towards a specific aspect of this epidemic. Activities aimed at preventing the spread of HIV/AIDS should be a rightful concern of the State Legislature and the Governor. While recognizing that the State's budget deficit will make it difficult to allocate State funds for this purpose, it is essential that the Legislature find some way to fund HIV/AIDS education for Montana's

residents. (Other recommendations in this Plan call for funding participation by local government and by the private sector for other prevention/education activities. It is critical that the State recognize its responsibility as well since funding must be a responsibility shared by many to be sufficient to combat the epidemic.)

2. **The MDHES AIDS Program shall provide specialized training to staffs at HERR sites to enable them to address homophobia in the communities with which they work.**

Explanation: Several groups in Montana, including the Office of Public Instruction and some of the local health departments, have developed materials and strategies to be used by educators to enable audiences to assess their own homophobia and deal with it. This recommendation calls on the MDHES AIDS Program to gather together this information and train the HERR staffs to make use of it in their work.

3. **Additional public funding shall be sought to support the eleven Counseling, Testing, Referral, and Partner Notification (CTRPN) sites to enable them to meet the ever increasing demand for HIV testing. In addition to the federal funding which is made available for this purpose, county governments in Montana should work with the local health departments which operate the CTRPN sites to assure that funding is adequate. Since counseling and testing through CTRPN sites is not available in all counties, financial arrangements should be made for those counties without sites to help finance the CTRPN site within whose catchment area they fall.**

Explanation: The demand for HIV testing which saw a major rise after the announcement by Magic Johnson that he is infected with HIV, continues unabated. Ten of the eleven CTRPN sites indicate their funding is woefully inadequate. Many sites supplement the federal dollars they receive with funding from the county in which they are located. Others do not. Some CTRPN programs have moved to using volunteers to provide pre- and post-test counseling, because they do not have enough money to cover costs otherwise. During 1991 $74,749 from the Centers for Disease Control awarded to testing sites for counseling, testing, referral, and partner notification services. In addition to the awards to CTRPN sites, the Montana Public Health Laboratory received approximately $28,000 in 1991 for the performance of HIV tests. During this time period, 3100 tests were administered. (See Attachment X for more about this program.)

Local health departments have traditionally relied heavily on county dollars for support. Funding for HIV counseling and testing -- which is a prevention tool in that those

being tested are counseled about behavior which puts them at risk of HIV transmission -- is a legitimate expense for county government to bear. However, counseling and testing costs should not be borne solely by those counties where the CTRPN sites are located. Each county needs to participate in funding the CTRPN site most likely used by its residents.

4. **Private funding shall be sought to support the educational activities of the AIDS Community Based Organizations (CBOs) located in the State. Private businesses, individuals, and religious bodies in Montana should be looked to for most of the funds needed by the CBOs. A parent organization should assume responsibility for coordinating state-level fundraising activities of the CBOs and provide technical assistance for community-level fundraising by the CBOs. The MDHES AIDS Program shall nurture the development of any organization acting in this role.**

Explanation: There are nine AIDS-focused, community based organizations in Montana. (See Attachment X for list of the CBOs and more about their programs.) All indicate they are overwhelmed with the work they need to do and minimal funding they have to do it. At this time, each HERR site passes through a small portion of their funding to a CBO in their area. There are also a number of less formally structured AIDS task forces in communities around the State, some of which also need funding to accomplish their objectives.

There are untapped private resources which could be drawn upon for the funds needed by the CBOs and the task forces, but someone needs to develop a plan for how the entities might be approached in support of the CBOs, and to take responsibility for making the appeal or assisting the CBOs to seek this support. In some cases a unified appeal would be the only way the interest of these entities might be tapped. The development of a non-profit organization should be looked to for this purpose. The MDHES AIDS Program should assist the organization by providing support and contributing to the start-up costs necessary. The presidents of the existing CBOs should serve in an advisory capacity to the State and the organization in this start-up period. Over time the organization should examine its board make-up to assure that there is adequate representation of the CBOs on the board.

It should be noted that the CBOs are also active in providing support services for those with HIV/AIDS and their families and friends. Some provide emergency funds to clients; some are involved with the Care Consortia; and all provide support services of various kinds such as buddies

or support groups for persons with HIV/AIDS. The services of each CBO are based upon locally defined needs. All rely heavily on the use of volunteers for their work. None of this would change under the proposal to have the parent organization coordinate and assist with fundraising, and it is anticipated that some of the fundraising would benefit the CBOs' support activities as well as their prevention/education activities.

5. **Public and private funding for special projects aimed at HIV/AIDS education for the general population should be maximized.**

Explanation: From time to time public and private dollars are made available for projects aimed at HIV/AIDS prevention. The Montana Department of Health and Environmental Sciences AIDS/STD Program has procured some of these funds in support of educational programs such as that run by Out In Montana/ Montana Gay Health Project and Criticare. The AIDS/STD Program should continue to look for opportunities to apply for additional funding as it becomes available.

A particular project for which new private foundation grant support should be sought is for a one-time, highly visible, carefully-planned event to be known as "Montana HIV/AIDS Awareness Week," which would feature state-level and local activities. A twelve month lead time between awarding of funding and the Awareness Week would be required to develop the kind of program envisioned. Grant support should pay for staffing to plan the state-level activities and to assist localities in planning their activities and for projects proposed at the state and local levels. The MDHES AIDS Program should be responsible for identifying possible funding sources and applying for funding.

HIV/AIDS AND MONTANA'S YOUTH

School-Based HIV/AIDS Education

It is essential that school-age youth be a primary target for education about HIV/AIDS. They are Montana's future, and they need to be fully aware of the dangers of AIDS and how to protect themselves from contracting it as they move toward adulthood. Furthermore, youth want more information. HERR and CBO educators who have given school presentations report that every age group want more information on HIV/AIDS.

To effectively reach school-age youth:

- age-appropriate HIV/AIDS education should start in kindergarten and continue through grade 12;

- it should be offered within the context of education about human sexuality and healthy lifestyles, and information about AIDS should be integrated as well into other study areas whenever possible;

- in addition to imparting facts about HIV/AIDS and its transmission, the AIDS curriculum should teach students communication and negotiation skills and promote feelings of self-worth and esteem to help prepare students to confront challenging situations;

- the HIV/AIDS educational offerings should be interesting and engrossing for the students, using games, role playing, speakers with HIV/AIDS, drama, and other approaches to make them so.

Special emphasis needs to be given to HIV/AIDS education among teenagers since they are at an age when experimentation of many kinds, including sexual, is common and when feelings of invincibility can lead to careless behaviors which can result in negative consequences (including contracting HIV -- a deadly outcome). With teens,

- messages about how HIV is transmitted and how to avoid becoming infected should be presented in language which is very clear, direct, and explicit -- teens indicate they have no problem with straight-talk and they need to know this information;

- peer education, with teens talking to teens about HIV/AIDS, will be particularly effective. The Save Our Kids (SOK) teen group in Missoula, started and operated by teens for teens with support from the Missoula City-County Health Department and the Missoula School District, is an example of a successful peer group effort that should be

replicated;

- the message that abstinence is truly the only way to avoid sexual transmission of HIV is important and should be stressed but, in recognition of the fact that more than 60% of the teens surveyed in 1991 by the Montana Youth Risk Survey indicated that they have had sexual intercourse, proper use of condoms must be taught.

The Montana Office of Public Instruction (OPI) receives funds from the Centers for Disease Control for a variety of HIV/AIDS educational activities aimed at school-aged youth. Under the CDC-funded program, OPI has developed and distributed to all schools curriculum planning guidelines and model HIV/AIDS curricula for elementary, junior high, and senior high classes. They have developed and distributed to all schools model policies for schools to use or adapt concerning communicable diseases (including HIV) among students and staff. OPI has also trained approximately 1500 teachers and administrators who themselves have trained others and have taught HIV/AIDS education. Further, OPI carries out knowledge assessment activities. (More information about OPI's HIV/AIDS educational program may be found in Attachment X.)

Issues/Problems

Schools may elect to use the model curriculum and policies developed by OPI, or develop their own, or have none -- and many school districts have chosen the latter course. A statewide survey of grade 7-12 school principals conducted in April and May 1990 regarding the availability and extent of HIV prevention education in Montana schools reported as follows:

> It appears that few Montana schools have provided the kinds of education that will be effective in enabling students to adopt healthy behaviors and to avoid preventable diseases. Specifically:
>
> - Fewer than 60% of schools with 7th and 8th grade classes provided any kind of HIV prevention education during the school year.
>
> - Fewer than 45% of schools with classes in grades 11 and 12 provided any kind of HIV prevention education during the school year.

Further, OPI notes that:

> According to current health education research, it may take as many as 30 hours of instruction during the school year to provide students with the kind of education that would enable them to adopt healthy behaviors and to avoid

preventable diseases. Effective HIV prevention education is best accomplished within a comprehensive health education program that emphasizes the development of skills and self-esteem. As part of a comprehensive school health education program, five or more hours devoted to the HIV prevention component during the school year are indicated.

But the survey found that:

- Fewer than 50% of schools provided HIV prevention education integrated into comprehensive school health education in grades 7 through 10.

- Fewer than 10% of schools with 11th and 12th grade classes provided HIV prevention education integrated into comprehensive school health education to students.

OPI's goals have been to increase the number of junior high and senior high schools that provide effective HIV/AIDS education to 75% with specific objectives for students at each grade level (80% of 7th, 8th and 9th graders; 90% of 10th graders; 35% of 11th and 12th graders).

To many the fact that many schools do not offer HIV/AIDS education is unconscionable given the deadly consequences. While all would agree that it would be ideal if each school district would elect to make HIV/AIDS education available voluntarily -- with school boards, parents and teachers all urging this, it has not happened. Therefore, as onerous as requirements are generally felt to be, it was the opinion of the Planning Advisory Council that schools should specifically include HIV/AIDS education within their health enhancement programs which they are required to implement under the Montana School Accreditation Standards. In doing this, Montana would join the 32 other states which now make HIV/AIDS education in grades K-12 a requirement.

To assure that teachers are prepared to teach about HIV/AIDS, other recommendations are made. There is also a recommendation promoting the development of student peer group activities as they relate to HIV/AIDS.

Recommendations:

1. **HIV/AIDS education shall be available in grades K-12 in every public school in Montana. Further, the basic information which must be taught in each grade, as already identified by OPI, should be made part of a comprehensive school health curriculum by specifically including HIV/AIDS Education in the Health Enhancement Section of the Montana School Accreditation Standards.**

Explanation: It is not recommended that every student be required to take these offerings nor that every teacher be required to teach them. However, every grade in every public school, under this recommendation, must make HIV/AIDS education available. If teachers are not comfortable teaching about sexuality issues or do not feel adequately prepared or up-to-date on AIDS issues, these feelings should be respected. However, each school district needs to make some arrangement to assure that its schools are prepared and willing to teach about HIV/AIDS.

At the present time, HERR sites and CBOs have conducted events to increase HIV/AIDS awareness and the need for school and community-based education. However, HERR funding is limited. In the event that HERR sites are relied on to continue or expand this role in school settings, decisions regarding financial support need to be made.

OPI has identified the basic information which should be taught about HIV/AIDS and has distributed it to all school districts. The present recommendation is that schools should be required to implement this or develop and use material of equal quality and similar content.

It is also hoped that, beyond having a course or curriculum module which covers HIV/AIDS specifically, teachers of subjects other than health will find ways to incorporate content about HIV/AIDS in their material as suggested by the comprehensive school health curriculum.

2. **The Office of Public Instruction's program to train teachers to offer HIV/AIDS training to teachers should be continued.**

Explanation: The Office of Public Instruction's program to "train the trainers" has been important in preparing teachers to teach about HIV/AIDS and enabling those they train to teach other teachers. This worthwhile program needs to be supported.

3. **Institutions of higher education in Montana which prepare primary and secondary school teachers should add as a requirement for graduation a class on HIV/AIDS and its transmission and a methods course on teaching youth about this and how to avoid contracting the disease.**

Explanation: Steps need to be taken to assure that future teachers are prepared to teach about HIV/AIDS. At this time a pilot program is underway in Bozeman to train teachers. Results should be used to institutionalize such programs. It should be noted that OPI has supported such a

requirement in the past, and their HIV/AIDS education grant from the federal government lists this as a need.

4. **MDHES, LOCAL HEALTH DEPARTMENTS, LOCAL SCHOOL DISTRICTS and OPI should jointly support the formation of local, school-district-based, teen peer group organizations which could advise the district on matters related to HIV/AIDS education in the schools, serve as a sounding board for their fellow students concerning matters related to HIV/AIDS, and encourage health-promoting behaviors among their peers.**

Explanation: The Save Our Kids (SOK) group currently fulfilling this role in Missoula provides a model for what can be done. Local health departments could serve as a resource for these activities.

HIV/AIDS AND SPECIAL POPULATIONS

A. Persons Who Practice High-Risk Behaviors

In addition to the AIDS prevention and education activities aimed at the general public and at school-age youth as discussed in the previous sections, it is important that education be directed towards adults who continue to practice high risk behaviors. This is because, even if persons know what to do to protect themselves, behavior change is never easy and frequently requires reinforcement and assistance from others.

The primary modes of transmission of HIV continue to be among:

- men who have unprotected sex with other men;
- intravenous drug users who share needles; and
- persons who have unprotected sex with these people (usually women).

As may be seen in the previous section of this Plan which reviews the dimensions of HIV/AIDS in the State, men who have sex with men has been the preponderant population group which has contracted AIDS in Montana. As of September 30, 1992, fifty-nine percent of those with AIDS have indicated that their exposure was due to this. Another twelve percent indicated a combination of homosexual/bisexual behavior plus intravenous drug use. Thirteen percent of those with AIDS reported IV drug use without homosexual/bisexual activity while five percent, all women, reported that they contracted AIDS through heterosexual contact.

The MDHES AIDS Program contracts for education which is targeted at homosexual and bisexual men (the latter are an extremely difficult group to reach as they often do not identify themselves as bisexual, are sometimes married, etc.). Among other things, this contractor operated hotlines available to anyone but was directed toward responding to the questions and concerns of gay and bisexual men. It is important that such activities continue and, ideally, be expanded. It is also important that the programs utilize gay and bisexual men as their health educators and on call for hotline referrals so that persons accessing the services feel comfortable in discussing their concerns.

There is no formal activity taking place to reach intravenous drug users or those who have other chemical dependencies (and may engage in risky behaviors while under the influence of alcohol or drugs). Nor is there any educational program which primarily targets women (here too, finding women at risk poses a formidable challenge). These populations should be targeted for attention.

It should also be pointed out that public health officials around the State and volunteers working with persons who engage in high risk behaviors believe that many of the persons at highest risk

are not coming in for HIV testing. Among the reasons identified for persons' not coming forward for testing are:

* fear that the person will be recognized by those doing the counseling and testing or others at the site and that if the test results are positive, the information will get out in the community and the person will be ostracized (some of the fears are well-founded as there have been instances where confidentiality has been breached and where persons who are HIV positive have been rejected by family and friends);

* denial either that one has actually engaged in high risk behavior or that partners are "the kind" that one should worry about (for example, if risky sexual behavior took place under the influence of alcohol and the individual was not aware it happened, or if one does not admit that same sex activities put one at risk since he is not a "full-time" homosexual or bisexual); and

* not wanting to know of one's HIV status for any of a number of reasons.

Needless to say, getting persons at high risk for HIV in for counseling and testing is extremely important in that it provides an opportunity to educate the person one to one and to answer any and all questions he/she might have about modes of transmission and how to protect oneself from contracting HIV, or transmitting it to others if infected.

Recommendations:

The following recommendations reflect the points made above.

1. **The MDHES AIDS Program shall continue to fund HIV/AIDS education activities targeted toward gay and bisexual men who continue to practice unprotected sex. Additional funds should be sought to expand these activities.**

2. **The MDHES AIDS Program shall work with the chemical dependency treatment agencies in the State to develop HIV/AIDS prevention/education projects which target IV drug users and others who abuse alcohol and drugs. The goal should be to develop a program in one geographic area in the State each year. Funding for these efforts will need to be found by the MDHES AIDS Program.**

3. **The MDHES AIDS Program shall work with the community based organizations in the State to develop HIV/AIDS prevention/education projects which target women at**

risk for heterosexual transmission of HIV. The goal should be to develop a program in one geographic area in the State each year. Funding for these efforts will need to be found by the MDHES AIDS Program.

B. Culturally Diverse Populations Including Native Americans, Hispanics and Blacks

Background

To a large extent, of course, issues and problems facing Montanans generally with respect to the AIDS epidemic affect Montana's minority populations as well. For example, the challenges inherent in bringing educational messages to persons separated by vast geographic distances are common to all and not dependent on the particular population to be reached. Likewise, denial that HIV/AIDS will personally affect oneself and feelings of homophobia may be found among persons of all races and ethnic origins.

At the same time, there are issues and problems related to the AIDS epidemic which are unique to Montana's ethnic minority populations. And, there are subsets of these populations which experience different issues and problems. For example, urban Indian populations may face problems not found among Indians on the reservations and vice versa, and one Indian tribe may see things differently than another, requiring that particular strategies and interventions used to respond to the identified problems be different depending on the target population. With regard to Hispanics, there are language issues, and there are cultural differences among Hispanics who are residents of Montana and those who are in the State part of the year as migrant workers.

One of the reasons that it is important to direct attention to Montana's ethnic minorities when discussing HIV/AIDS prevention is that ethnic minorities including (Blacks, Hispanics, Indians) are disproportionately represented nationally and among Montana's AIDS cases. In Montana they constitute 13% of resident and non-resident AIDS cases (actual number 18 as of September 30, 1992) while making up only 7.8% of the population. Furthermore, the profile of Montana's minority AIDS cases differs from that of the other AIDS cases. Though X of the 18 cases were men who had sex with men, with or without IV drug use, X of the minority AIDS cases were women (as compared with __ of the total of __ AIDS cases among whites). And the only two pediatric cases in Montana were among minorities, specifically among Native Americans.

Because the actual total number of persons from ethnic

minorities in Montana who have contracted AIDS is small, the picture of AIDS among these populations may change over time. If, however, what has happened to date is representative of what will happen in the future, there is cause for concern if nothing were done to alter these trends.

Before looking at what programs are in place and what else needs to be done, it is important to recognize that HIV/AIDS is not the chief problem facing some of Montana's ethnic minority communities. There are frequently other social and health problems which present monumental challenges to those communities and populations and those working with them. Poverty and unemployment, and alcoholism and fetal alcohol syndrome are among these. Somehow a balance needs to be struck between bringing life-saving prevention/education messages about AIDS to Montana's minority populations while also dealing with other more prevalent social and health problems.

Overview of HIV/AIDS Educational Programs Targeted Toward Ethnic Minorities

A variety of HIV/AIDS educational activities directed toward **Native Americans** have taken place, both on the reservations and in the urban areas. The Indian Health Service area office designates an AIDS Coordinator on each reservation who has primary responsibility for getting the word out about HIV/AIDS, how it is transmitted, how to avoid contracting it, the importance of counseling and testing for those who are at risk and where testing can be obtained. Though these coordinators add their HIV/AIDS assignment to their already-full-time workload, there are funds available from the IHS on a grant basis to support good ideas submitted by the coordinators for prevention/education activities. A large conference, jointly sponsored by a variety of Native American organizations, titled "AIDS- A Community Affair" was held in Billings and attended by nearly 500. In the urban centers, the IHS makes available some funds to the urban Indian clinics for AIDS education, though the amount is generally felt to be insufficient to do the job which needs to be done (see issues section below).
In both the urban and reservation programs, a number of innovative and clever -- as well as more usual -- approaches to HIV/AIDS education have been used. Brochures with an Indian focus have been prepared and distributed. PSA announcements and part of a regular TV program on public access television have been used. Teepees are set up at pow wows with information on HIV/AIDS, free condom distribution, etc. Picnics have been held with AIDS information presented by speakers. Dramas about AIDS have been presented by touring groups. Key chains, sweatshirts, and other paraphernalia with culturally appropriate AIDS messages have been distributed. Videos prepared by Indians, for Indians, on HIV/AIDS are played by some clinics during regular clinic hours. And on and on.

Besides these efforts, the Montana United Indian Association has received grants from the MDHES to carry out a variety of prevention and education activities including train-the-trainer programs at tribally controlled college and Native American studies programs, outreach to Native Americans in the State Prison and in chemical dependency centers and to other Native Americans in urban and reservation areas who practice high-risk behaviors, and coordination of the Montana Minority Task Force. The MUIA grants also calls for a needs assessment of HIV/AIDS prevention/education activities carried out by organizations and institutions serving Native Americans. Efforts in these areas will continue through grants with the Little Shell Tribe.

HIV/AIDS education directed toward **migrants** has been carried out by the Montana Migrant Health Council located in Billings under a small grant from MDHES. The challenges inherent in reaching migrants with information about HIV/AIDS and assuring that those

desiring HIV testing and counseling get it, are many. There is no natural forum where the HIV/AIDS educational message can be delivered; some migrants are not literate, so written material is of limited usefulness; information must be communicated in Spanish as well as English and must be culturally appropriate (as with women delivering information to women and men to men). Clearly more resources than are presently available would be needed to assure an effective educational program within the migrant population.

There are no programs at this time directed specifically at Hispanics or Blacks living in the State.

Issues/Problems

Some persons in Montana's minority communities are still ill informed about aspects of HIV/AIDS and how it is not transmitted.

Examples from 1991 Youth Native American Survey will be added to text.

Further, there is a feeling that many minority persons who have engaged in behaviors which put them at high risk for contracting HIV have not been tested for the virus. While many of the reasons that members of the minority community have not come forward for testing are similar to those of the whites, concerns about being recognized and confidentialities breached are even greater in minority groups where the size of their population is so much smaller.

There seems to be widespread agreement that to tackle these problems and encourage more persons who are at risk to get tested for HIV, several things must happen. First, the present educational efforts concerning HIV transmission and the importance of being tested for the AIDS virus must continue and must be expanded. People usually need to hear messages more than once and the medium which may work for one may not work for another. This will require additional resources beyond what is now devoted to this effort.

Further, coordination and sharing of information about strategies which do and do not work and analysis of why, need to take place between program staffs. For Indians, those would include urban and reservation staff persons responsible for HIV/AIDS activities along with staff members from the Area Office of the Indian Health Service, the MDHES AIDS Program, and programs MDHES contracts with, such as the Montana United Indian Association.

The Montana Minority AIDS Task Force could be a vehicle for accomplishing this and for bring the Montana Migrant Council into these discussions as appropriate.

Whatever is done regarding HIV/AIDS education in the minority community, there is concurrence regarding certain desireable aspects of prevention/education programs. These are as follows.

* Information about transmission and testing is best presented within the context of a larger HIV/AIDS educational program which addresses the denial that HIV/AIDS is already in one's community.

* Educational activities need to be "owned" by the group who is to give and receive the message (e.g., with regard to reservation Indians, involvement of Tribal Councils and elders is important as programs are designed and implemented).

* Peer education wherein "like" educates "like" will be most effective.

* Material and approaches must be culturally sensitive, appropriate and relevant (for example, use story telling and knowledge bundles in communicating important messages within Indian communities).

* Small groups discussions (especially in very rural areas) and large conferences are important mechanisms for educating people about HIV/AIDS. In some cases, outreach to individuals and families should also be used.

* Special efforts need to be made to reach people who do not recognize that when they drink at celebrations and at other times and engage in unprotected sex, that they are putting themselves at risk for HIV.

* Adolescents must be a focus for targeted educational activities.

Recommendations:

Given the previous points, the following recommendations are made.

1. **More resources should be found to support HIV/AIDS prevention/education activities directed toward Montana's minority populations.**

   Explanation: For education within Native American communities, several urban sites indicate they need Community Health Representatives to reach people where they

may be found. This is especially important for those urban locales where past efforts have not succeeded in getting people in for testing. These sites also indicate that they need health educators.

On the reservations, it would seem important that the AIDS work of the AIDS Coordinators should be part of their regular paid time. Other IHS AIDS funds need to be targeted toward priority communities which have not yet succeeded in getting people in for testing. Since IHS AIDS funds for special projects have more than tripled in 1992 over 1991 ($135,000 vs. $42,000), significant strides should be possible.

For Hispanics, more money for outreach to migrants is desireable, and new activities for the resident Hispanic population in Billings should be initiated.

2. **The Montana Minority AIDS Task Force shall coordinate the activities of various groups which are working to educate Montana's minority populations about HIV/AIDS and should assist MDHES in ongoing planning aimed at identifying program gaps and designing approaches to deal with these. MDHES shall identify funding which will allow the Montana Minority AIDS Task Force to carry out these responsibilities.**

Assuring Treatment & Support Services for Persons with HIV/AIDS

This section of the Plan does not contain its own set of recommendations. This is because, for the most part, the steps which are outlined to address the deficiencies identified in treatment and support services are covered elsewhere in the Plan, especially in the Leadership/Infrastructure section. The discussion in this section, however, should help to clarify the need for some of the actions recommended elsewhere and to underscore their importance.

TREATMENT

Background

Because there are so few persons with HIV/AIDS in Montana and those who are infected are not concentrated in only a few communities (31 of 56 counties reporting at least one case), the burden placed on the health care system in caring for these persons has been light compared to that in many other places across the U.S. Though the epidemic has clearly had some impact on the system, as caring for persons with HIV/AIDS does consume more resources and time than reimbursement compensates, the burden has been bearable to date. And it is anticipated that, even with the projected growth over the next three to five years in the numbers of persons with HIV/AIDS in Montana, HIV/AIDS will not constitute an unmanageable problem for the system. The physicians who are seeing persons with HIV/AIDS have not been overwhelmed; Montana's hospitals have the capacity to serve anyone needing inpatient care; and the federal dollars flowing into the State for care services have been sufficient to meet the needs.

On the other hand, however, for a particular individual with HIV/AIDS who is seeking services, there can be problems in accessing care. And there are issues related to how that care is being provided and paid for. These issues concerning treatment, support services, reimbursement and insurance, are delineated here.

Issues/Problems

Medical and Dental Care. Physician and dentist availability is uneven across the State.

In a number of the fairly remote communities the local physician(s) is(are) not willing to see persons with HIV/AIDS. The reason they usually give is that they believe physicians who regularly treat persons with HIV/AIDS would better serve the patients. (It should be noted that there is a shortage of primary care physicians overall in Montana, but among those who are there, not all will see persons with HIV/AIDS.) Some observers

think it is true that a number of physicians are not knowledgeable but believe they should be, and many are thought to be homophobic. (While pointing out that there are a number who "are not comfortable" seeing patients with HIV/AIDS, it should be noted that some have risen to the occasion and worked diligently with specialists in referral centers to manage the patients' care so the patient can stay in their community throughout their illness.)

Beyond the situation in Montana's smaller communities, while care for persons with HIV/AIDS is readily available in most -- but not all -- of Montana's larger cities, generally only a handful of physicians in these communities are seeing these patients. Furthermore, physician specialists are also uneven in their willingness to care for persons with HIV/AIDS.

Availability of dental care is even more problemmatic. In many of the larger communities in the State, there is not a single dentist who will see persons with HIV. In some where they will, they make the patient "jump through such hoops" that it is humiliating and demoralizing (e.g., "come in after hours and after the staff has gone home"; "try the other dentists and if no one will see you, have the health department give me a call").

In the Leadership/Infrastructure section of this Plan, we call on the professional associations to help increase the number of providers available to care for persons with HIV/AIDS. At a minimum they need to advise their members that refusal to treat is not allowed under the law in Montana. Beyond this, though, they are asked to educate their membership so that they will be ready and willing to see persons with HIV/AIDS.

Skilled Nursing. Skilled nursing facilities (nursing homes), though required by law to accept persons with AIDS, have been able to maneuver around this requirement since they run at or near capacity and can find excuses for not admitting persons of whatever stripe (low pay/no pay/difficult to deal with/etc.). Though high occupancy is part of the problem, a greater problem in the cases where persons with AIDS have not been admitted has been the reluctance of nursing home administrators and floor staff to deal with their own fears about AIDS and with the fallout they anticipate from other residents and families if AIDS patients are admitted. The SNFs which have accepted persons with AIDS have successfully addressed such issues; so, it can be done. Though traditional-type SNFs are not ideal placements for persons with AIDS, they are the only residential long-term care alternative available in Montana to serve persons in need of this level of care. Hence their compliance with the legal mandate not to refuse service to persons with AIDS must be enforced. We call for this in the Leadership/Infrastructure section of this Plan.

Hospice. Home health and hospice care are available for persons

with AIDS across Montana and have been accessed by these persons. The problem has to do with reimbursement for hospice care under Medicaid and Medicare. Persons with AIDS utilize considerably more medications than the average hospice patient, and, since reimbursement is capitated based on average costs, Montana's hospice agencies are concerned that, if they have more than a small number of persons with AIDS over time, it will create financial hardships for the organizations. Since most hospice agencies regularly run at a financial deficit already, this could bankrupt them. In order to begin to address this problem, the hospice agencies need to document the amounts they are spending for medications above the usual expenditures. Then discussions could begin with the State Medicaid Office to see what can be done about this.

Mental Health Services. In the past, mental health services have been inaccessible to a large number of the individuals with HIV infection due to lack of resources. However, HIV-related counseling is currently available through regional HIV Care Consortia (see attachment XX for more information).

Emergency Medical Services. There is a need for much more education to take place with EMTs (and firefighters and police) on universal precautions and on the importance of maintaining confidentiality of medical information on those they serve.

Care Consortia. The Regional HIV Care Consortia, established in 1991 in response to the federal Ryan White Comprehensive AIDS Resources Emergency Act of 1990, are still sorting through the processes they will use to pay for care services for persons with HIV/AIDS. (See Attachment X for more information on these bodies.) More definition needs to be given to which aspects of their programs need to be standardized throughout the State and what can be determined at a regional level. For example, should all consortia be required to pay for similar services for persons with HIV/AIDS or can each consortium decide for itself, and should all be paying the same amounts for services or is local discretion allowable? Over the next twelve to eighteen months the State AIDS Program should assist in clarifying these and other issues related to centralization/decentralization of consortia operations. The goal, of course, should be to maximize service to clients with appropriate guidance coming from the State to the regions as they develop their programs.

SUPPORT SERVICES

Issues/Problems

Case Management. Case management services, supported with Ryan White funds and provided through the Care Consortia, are a cornerstone in any HIV/AIDS continuum of care. However, they are

especially important in Montana where there are not enough AIDS cases to develop AIDS-specific programs and services, and each person with HIV/AIDS will need during the course of their illness to wind his/her way through a variety of care and reimbursement systems. Case managers will be the only ones who can provide continuity to these folks over time.

Because the Care Consortia are so new, they have not all gotten their case management programs up and running. As this happens there will be a need to develop common definitions across the State about what case managers are to do (allowing, of course, for considerable flexibility and latitude to assure that case managers meet local needs). Other aspects of the use of case managers may also need to be standardized (e.g., way case management services are paid for, consistency in background and capabilities of those serving as case managers). Also, it will be important to assess the knowledge and beliefs/attitudes of case managers (re: homosexuality, IV drug users) as some case managers come from other organizations/settings where these have not been issues. If there are problems here, they will need to be addressed. Further, some case managers coming from other systems may need basic education about HIV. The State AIDS Program, working with the regional consortia, will need to address these issues over the next twelve to eighteen months.

Community Based Organizations. The nine community-based organizations located around the State are an essential component in Montana's response to the AIDS epidemic. The CBOs frequently provide the primary support for persons with HIV/AIDS in their communities and, since the CBOs are physically located in the community they serve, they are able to respond to client needs in a way no outside organization could do. In the Prevention section of this Plan, a strategy to increase the funding for these organizations is proposed. Such funding could benefit the CBOs in supporting their care services as well. The recommendation to establish a parent organization to act as a conduit for fundraising and for coordination and communication between CBOs is reiterated here.

AIDS Task Forces. A few communities in Montana have AIDS task forces which are less formally organized than the CBOs, and in some cases consist of just a handful of people who might be interested in assuring that persons who might need services or support in their community can get them or that AIDS education is available to residents of the community. In some cases it is likely that, over time, the task force may become a CBO. In any case, their work should be supported and the MDHES AIDS Program should develop a way wherein these groups can receive updated information about the epidemic and be assisted to network with each other when it would be useful.

Volunteers. Volunteers are very numerous and very active in the

AIDS epidemic in Montana. They are the backbone of the CBOs, but they are active in many other communities in many ways. Also, many paid staff (such as county health department employees, Red Cross employees, hospital employees) are spending off-hours on AIDS-related activities. For some this is just a spill over from their paid work because they are committed and there are not enough hours in the day, while others are doing different types of activities in non-work hours.

The problem is that it is hard to sustain volunteer efforts without paid volunteer coordination. Volunteer coordinators are important for volunteer training, scheduling and deployment so that the best use can be made of volunteers, and for "care and feeding" of volunteers to avoid burnout. Funding should be found to support paid coordinators (need not be full-time, at least initially) in the larger communities which have the greatest number of residents with HIV/AIDS. The volunteer coordinators should ideally be employees of the local CBO unless they are in a community where the health department or an area hospital is a more logical location. The Montana AIDS Fund should seek private funding to underwrite the costs of paid volunteer coordinators.

Telephone Support Network. For the reasons identified in the Attitudes section of this Plan, many persons with HIV/AIDS in Montana are afraid of being identified as infected with HIV. Nor do their families, significant others, and friends feel that they can be open with others on this matter. In such cases there is frequently a sense of real isolation. If a person is not afraid of being known and if there is a local CBO, the person can likely find a support group or at least a buddy with whom to talk for support. But, given that it will take time to change attitudes, some alternative to physical presence at support group meetings is needed in Montana. Fortuitously the national organization, Parents and Friends of Lesbians and Gays, has recently initiated a program which will provide persons affected by the AIDS epidemic with a contact in their state of residence to assist them in finding someone with whom they can network via the telephone for support. This should be especially useful in Montana for, say, a parent who is grieving the loss of a son and wants to talk with someone else who has gone through a similar situation, or for a teenage sibling of someone infected with HIV who is not comfortable talking to schoolmates about their situation but needs to talk to someone their own age. This network should be supported. The Montana contact may be reached at 1-800-4-FAMILY (1-800-432-6459).

Other Support Service Issues: There are several areas which will need to be addressed over the three to five year time span covered by this Plan though they are not as pressing as those areas covered above.

Housing/Residential Long-Term Care. One community already

feels need to develop something in this area; another says they need to get prepared when HIV/AIDS person needs housing; one community is currently assessing needs and will pursue planning if needs are found.

Counseling/Emotional Support. Some communities have developed this service; some are ready but have had no "takers"; some have not found counselors willing to see persons with HIV/AIDS or think counselors who are available are not equipped to deal with special emotional issues of persons with HIV/AIDS.

Care For Caregivers This is much needed but hard to do because who/where caregivers are is not always known (i.e. people pull back when burnt out). Paid respite care (that is, paid because it will be more than volunteers can handle) will be needed by more caregivers in the future in Montana.

FINANCIAL/INSURANCE

Background

All of the problems encountered by persons with HIV/AIDS related to the cost of care, to insurance eligibility and coverage, etc., are experienced by persons with other expensive, chronic illnesses as well. To address these universal issues, the current examination of the problems of the uninsured and underinsured in Montana by the Governor's Health Care for Montanan's Project should be supported, and the particular problems encountered by persons with HIV/AIDS brought to the attention of this body.

At the same time, the Montana Comprehensive Health Association (MCHA), as the cooperative association managing the state's high risk insurance program, should be alerted to the severe limitations of coverage which make this program essentially worthless for persons with AIDS and many other illnesses. (Compared with the coverage available through high risk programs in other states, Montana's is especially narrow, making it useless to many with chronic illnesses.)

A near-term strategy which would help individuals who, for the first time, need to access public assistance programs would be to prepare brochures or video or audio tapes which would advise the applicant about the application process. Information could include what to expect when applying for assistance, who is eligible for what, where to go and what information to bring to first meetings with eligibility technicians, what to expect when one gets to the office, etc. In time, when the AIDS case management program is fully functioning, this information will be available from the case manager. For the time being, however, there seems to be a need for this.

Building Leadership In The Fight Against AIDS

An effective response to the AIDS epidemic in Montana requires leadership. It also requires that certain processes and structures be in place to assure that this Plan is implemented and that planning becomes an ongoing process. A number of recommendations are made in these areas as they affect public sector entities and private sector entities.

A. RECOMMENDATIONS REGARDING PUBLIC SECTOR ENTITIES

1. **The GOVERNOR should constitute and support an HIV/AIDS Advisory Council, per 2-15-122 MCA, charged with overseeing the implementation of this Plan and establishing and administering an ongoing planning process to address the epidemic. The Council shall include representatives from communities affected by HIV/AIDS and from agencies and organizations working to prevent the spread of HIV and serving those infected with the HIV.**

   The Council should be adequately staffed and funded to carry out its important assignment.

2. **The MDHES AIDS PROGRAM shall take a leadership position in promoting sound public health policy as it relates to HIV/AIDS and its containment. Among the ways it should exercise this leadership are the following:**

   - **developing standards for HIV/AIDS programs operating in the State and providing technical and community organizing assistance for local communities as they devise their strategies to prevent the spread of HIV and to serve those with HIV/AIDS (this should include sponsoring opportunities for networking among like workers and volunteers in the communities, such as case managers or pre/post HIV test counselors);**
   - **continuing and expanding its role as a source of funding to combat the AIDS epidemic;**
   - **challenging the status quo wherever this is detrimental to the public's health; and**
   - **initiating an Interagency AIDS Work Group comprised of State employees and aimed at fostering communication and coordination among State programs which deal with aspects of HIV/AIDS and between these programs and other state-level organizations in the private sector and non-state, public agencies (such as IHS and the VA).**

3. **The STATE DEPARTMENT OF LABOR should take a leadership role in educating employers in Montana about the legal rights of employers and employees when employees have HIV/AIDS, about how situations involving workers with HIV and/or AIDS can be handled sensitively, and what the issues are regarding continuing health care benefits for employees with HIV/AIDS. The DOL should have available model employer/employee HIV/AIDS policies which businesses in Montana can use as they begin to develop such policies.**

(Note: The Office of Public Instruction has developed model teacher/student HIV/AIDS policies for schools to use in this manner, and this is the type of leadership being asked of the DOL with respect to private sector employers.)

4. **The HEALTH PROFESSIONS LICENSING BOARDS of the PUBLIC SAFETY DIVISION OF THE DEPARTMENT OF COMMERCE should aggressively enforce compliance with non-discrimination of persons with HIV/AIDS among their licensees.**

Explanation: Montana's Human Rights Act provides that it is unlawful for any employee of a public accommodation to refuse to provide services because of physical handicap. A hospital, clinic, doctor or dentist providing health care to the public is a public accommodation. A refusal by any of these to treat or to administer a blood test to a person who has AIDS is unlawful.

Though the Montana Human Rights Commission is charged with investigating complaints of discrimination when these are filed, it is not charged with seeking out perpetrators. Furthermore, the Commission's workload is so heavy that this would not be possible anyway without substantially more resources than it now receives. Since professional licensing boards have a powerful "stick" to hold over a licensee to influence them to abide by the law, and the boards do regularly receive complaints from citizens about licensees and act on some of these complaints, it is recommended that the boards identify refusal of licensees to treat persons with AIDS as a matter they will pursue.

5. **The MDHES HEALTH FACILITIES DIVISION should aggressively enforce compliance with non-discrimination of persons with HIV/AIDS among their licensees.**

Explanation. All facilities receiving federal funds such as Medicaid and Medicare are prohibited from refusing to treat persons with HIV/AIDS. In addition to Montana's Human Rights Act makes this illegal, Montana statute (50-5-105, MCA) prohibits health care facilities from refusing privileges based solely upon HIV infection.

6. **LOCAL HEALTH DEPARTMENTS shall continue serving as the lead agency in Montana's counties/communities in responding to the AIDS epidemic. Their activities should be aimed at:**

   * **preventing the spread of AIDS (including providing consultation and education to the community, offering HIV counseling and testing, and carrying out partner notification);**
   * **carrying out local surveillance and policy development activities; and**
   * **assuring that needed services are available for persons with HIV/AIDS (including maintaining a working relationship with others providing AIDS education and support services such as community-based organizations).**

7. **The INDIAN HEALTH SERVICE should coordinate its AIDS prevention and service activities with those of other public sector entities and the private sector and should engage in joint planning activities with these groups. In this way resources can be maximized and Native Americans can be assured continuity of programs and services regardless of where they are residing in the State or what their tribal affiliation is.**

B. RECOMMENDATIONS REGARDING PRIVATE SECTOR ENTITIES

1. **The MONTANA ASSOCIATION OF CHURCHES should develop a position paper on AIDS and people who contract it covering the following points:**

   - **AIDS is a disease and should be treated as such.**
   - **All need to be compassionate and humane toward those with HIV/AIDS.**
   - **Churches should strive to promote the worth and dignity of those infected.**
   - **All churches are encouraged to become involved with local task forces, in making meeting rooms available for support groups, in raising money for community-based organizations' emergency funds/housing support, etc., and in developing educational efforts for their congregations and the larger communities in which they are located.**

Explanation: Churches individually and collectively are in a unique position to provide moral leadership in responding to the tragedy of AIDS. People look to churches for guidance in clarifying values and in understanding ethical questions related to the disease. Furthermore, churches can provide both human and financial resources which can be utilized in the effort to contain the spread of HIV and to serve those infected with the virus.

Though some churches in Montana have been involved in responding to the AIDS epidemic, many are not yet actively involved. In recognition of the important roles they could play, the Montana Association of Churches is called upon to help "jump start" this activity and to sanction it.

The Montana Association of Churches is currently developing position statements regarding many of the subjects listed above. It is anticipated that this process will be completed in the latter half of 1993.

2. **The MONTANA MEDICAL ASSOCIATION, the MONTANA OSTEOPATHIC ASSOCIATION, the MONTANA DENTAL ASSOCIATION, THE MONTANA NURSES ASSOCIATION, and other professional and voluntary health associations should provide leadership in the following ways:**

   * **assuring that their members know it is illegal to discriminate against persons with HIV/AIDS by denying access to care and helping to police their own in this regard;**
   * **providing educational opportunities on HIV/AIDS for their members;**
   * **formalizing networks between primary care providers and specialists who are experts on HIV/AIDS, in Montana and elsewhere;**
   * **fielding complaints from community-based organizations and health departments when members are perceived to be creating barriers for persons with HIV/AIDS to get served;**
   * **advertising State programs (such as the Early Intervention Program and the AIDS Drug Program) to their members; and**
   * **working with MDHES to get AIDS cases reported and assuring that their memberships understand the public health implications of accurate and timely reporting.**

Explanation: Though some professional associations have lobbied the State legislature on issues their members have with respect to AIDS legislation, few

associations have taken a leadership role with respect to patient needs or educational programs for their members. This recommendation calls on all associations to do these things.

3. **The MONTANA FUNERAL DIRECTORS ASSOCIATION should promote the willingness of its members to bury or cremate the bodies of persons who have died of an AIDS-related disease.**

Explanation: A number of funeral homes in Montana will not currently accept bodies of persons who have died of an AIDS-related disease. The Association is called on to consider this problem, to take a stand, to educate directors of what is legal and what is not, to promote universal precautions, to deal with excessive fears about transmission, etc. The Montana Human Rights Commission considers funeral establishments to be public accommodations. As a result, policies or actions such as refusing services based upon HIV status would violate state and federal laws.

4. **The MONTANA HOSPITAL ASSOCIATION, working with INFECTION CONTROL PRACTITIONERS and OCCUPATIONAL HEALTH PRACTITIONERS, MDHES, and the HIV/AIDS Advisory Council to be created under these recommendations, should meet to discuss the need for modifications to State law regarding the requirements for pre- and post-test counseling and for obtaining informed consent when accidental exposures to bodily fluids occur in health care facilities. Any modifications should stress both the rights of source person and of the person possibly exposed. Any modifications should complement OSHA's standards regarding bloodborne pathogens. The procedures should strike a balance between responding to the very real fears of the persons exposed and not overreacting to the extremely small risk that any health care worker will contract HIV during exposure situations.**

Explanation: Hospital personnel often find it difficult to comply with the law as now written with regard to providing pre- and post-test counseling to source patients in exposure situations and delivering test results to these patients. For example, it is impossible in many instances to provide post-test counseling and deliver HIV test results in person to source patients when they have already been discharged. Discussion regarding such instances and what obligations a hospital has may correct these

problems. (However, discussions need to take place regarding the necessity to test source patients given the window period during which a person may not test positive for HIV antibodies even if infected with the virus and given that the person exposed should follow the same testing protocol regardless of the HIV status of the source patient.) The MHA, working with others, is called upon to address any problems that may exist.

The MHA could also develop a standard packet for all hospitals to use to deal with and track occupational exposures and follow-up. (It will be important when developing these materials to take into account the possible overreaction of health care workers to the likelihood of becoming infected with HIV through exposures to body fluids. Becoming infected is a rare event in any health care setting anywhere in the U.S. Policies should recognize the need for precautions without being excessive.)

During its deliberations, the group should also determine if the current provision in State law allowing only physicians to obtain informed consent in exposure situations should be retained or if this is in reality unworkable. At this time most physicians are delegating this responsibility to nurses. Whatever the outcome of these discussions, it should be made clear to all exactly who can legally obtain informed consent, and consistent practice across the State should become possible.

Preserving Human Rights And Dignity

This section of Montana's AIDS Plan addresses several important policy questions and recommends positions which are consistent with the preservation of human rights and dignity and with promotion of the public's health.

The four policy areas are:

A. Non-Discrimination
B. Decriminalization of Homosexuality
C. Confidentiality And The Need To Know
D. HIV Reporting Requirements

A. NON-DISCRIMINATION

Current Law:

The Montana Human Rights Act and Montana Governmental Codes of Fair Practices prohibit discrimination based upon physical handicap in employment, public accommodations, housing, financing, education and government services. Federal court rulings have established that HIV/AIDS is a physical handicap.

Montana employers may not refuse to employ persons with HIV/AIDS who are qualified for employment unless an individualized evaluation, based upon reasonable medical judgement, establishes a risk of harm. Such an evaluation should consider:

* the nature of the risk;
* the duration of the risk;
* the severity of the risk; and
* the probability that the disease will be transmitted and cause harm.

Employers must also make reasonable accommodations which allow qualified employees with HIV/AIDS to perform their jobs.

The Americans with Disabilities Act (ADA) was passed by Congress in July 1990. This law protects persons with disabilities in employment, education and service availability. The ADA protects those that are perceived as having HIV, are HIV infected, or are living with AIDS. Under the ADA, businesses with more than 25 employees are prohibited from discriminating against persons living with HIV/AIDS. The law will be expanded in 1994 to include businesses with 15 or more employees.

Issues

Despite the statutory prohibitions against discrimination, throughout the nation since the beginning of the AIDS epidemic, people with AIDS have been rejected by family and friends, verbally harassed, physically assaulted, evicted from their houses, fired from their jobs, and denied medical and dental services -- or humiliated when seeking services by being asked to come "after hours" or "through the back door" so others would not see them. In a 1989 survey of persons with AIDS across the nation, 43% reported having experienced discrimination. And, not only are those infected with HIV discriminated against, but frequently their families and friends are as well. (M.B. King. Prejudice and AIDS: the views and experiences of people

with HIV infection. AIDS Care 1989, 1:137-143.) Within Montana, attorneys and community based organizations which deal with persons with HIV/AIDS indicate they have had calls from persons who have been discriminated against in various ways and who want to know their options for redress. For more information on discrimination refer to "Attitudes" in the section titled "HIV/AIDS and the General Public."

The stigma attached to HIV/AIDS is no doubt due to a number of factors. HIV/AIDS is contagious and life-threatening. It is transmitted in ways which are objectionable to many (and sometimes actually illegal or associated with illegal activities).

From the perspective both of promoting the public health through controlling the epidemic and of fostering the dignity of individuals, discrimination is harmful. Fear of discrimination can discourage people from seeking HIV counseling, testing and early treatment and can be deleterious to a person's mental health as well, diminishing self-esteem and feelings of self-worth of those discriminated against.

Montana's laws prohibiting discrimination are good ones and, coupled with the national statutes, should provide adequate protections in the areas covered (housing, employment, etc.). The problem is that there is such a long lead time between the date a person files a complaint about a discriminatory incident and the resolution of that complaint. This process can stretch out for years and in the meantime the person must continue to live not only with the first discriminatory action but also possibly be the victim of others. There is some protection of complainants in that complaints with Montana's Human Rights Commission can be filed under John and Jane Doe identifications. However, the effort required, especially if one is ill, and the problems associated with the long wait dissuade individuals from filing.

Furthermore, beyond discriminatory acts which are clearly illegal, Montana is not immune to the types of invidious day-to-day types discrimination experienced by those with HIV/AIDS and their families and friends which fall outside the bounds of legal sanctions. And the link between the criminalization of homosexuality in Montana and issues of discrimination cannot be denied. (This Plan calls for repeal of the law making homosexuality illegal.) Likewise, the potential for instances of discrimination connected to breaches of confidentiality (which occur despite legal sanctions against them) must be acknowledged. (This Plan also calls for strengthening and enforcing Montana's laws

regarding confidentiality.)

One strategy for addressing discrimination against persons with HIV/AIDS is that HIV/AIDS education programs and messages at all levels should routinely promote respect as well as empathy for people with HIV/AIDS and their family and friends and, when possible, feature such persons as part of the educational program. Educators should actively dispel myths, stereotypes, and biases toward people with HIV/AIDS and those communities at highest risk.

Policy Recommendations

In recognition that discrimination toward HIV infected persons creates a major obstacle to stemming the spread of HIV and to adequately care for those with HIV disease, the following recommendations are made.

The present State statutes prohibiting discrimination against persons with HIV/AIDS should be preserved and enforced.

Resources should be found to enable the Montana Human Rights Commission and other agencies responsible for responding to alleged HIV-related discrimination to expedite the investigation of complaints from persons with life-threatening illnesses so that a resolution of the complaint may be reached while claimants are still living. Further, identities of persons filing charges should be kept confidential, except as release of information is required by law, and people should be informed that they may file complaints with the Human Rights Commission anonymously.

B. DECRIMINALIZATION OF HOMOSEXUALITY

Current Law:

The Montana statute on Sexual Crimes makes "deviate sexual conduct" illegal. The Act says, "A person who knowingly engages in deviate sexual relations or who causes another to engage in deviate sexual relations commits the offense of deviate sexual conduct. "Deviate sexual relations" are defined as sexual contact or sexual intercourse between two persons of the same sex or any form of sexual intercourse with an animal.

If convicted of deviate sexual conduct, a person could be imprisoned for up to 10 years or be fined up to $50,000, or both. If convicted of deviate sexual conduct without consent, the term of imprisonment can be up to 20 years and/or a fine of up to $50,000. (Montana is referred to around the nation as one of "the dirty dozen" states with the toughest maximum penalties for illegal sexual activities among consenting adults.)

There have been periodic attempts to try to remove this law from the books, the latest effort taking place during the 1991 legislative session. Debates regarding rescission of the law are always emotionally charged and acrimonious. Though the last attempt did not result in decriminalizing homosexual activities, it did result in a modification of the Sexual Crimes Act to prohibit the use of information regarding someone seeking testing for HIV in prosecution proceedings under the deviate sexual act.

Issues:

Despite the recent change regarding the use of information about persons being tested for HIV, there is a widespread belief that the law continues to create a barrier to testing and impedes the promotion of the public's health in other ways. The law hinders the identification of those needing education about HIV/AIDS and discourages people from coming forward for medical treatments and for testing for sexually transmitted diseases other than HIV. (There are other reasons why many believe the law making same sex activity illegal is bad public policy -- not the least of which is that the law likely violates the State constitution's right to privacy. However, the deterrent to the promotion of the public's health is the primary concern which this Plan on HIV/AIDS needs to reflect.)

Though some tend to dismiss the importance of the law because they believe it has never been used to prosecute anyone, this is not correct as there have been several

instances where charges have been brought against individuals. Regardless, even if rarely enforced, the maintenance of the statute creates a climate for stigmatizing and discriminating against gays and lesbians, for in fact they are felons in the eyes of the law. (Ideally, of course, all persons should be offered equal protection under the law regardless of their sexual orientation, but at a minimum none should be considered criminals on the basis of their sexual orientation.)

During the 1991 legislative session the Montana Department of Health and Environmental Sciences went on record in supporting the decriminalization of homosexuality. Other entities concerned with public health in Montana have also stated their support for repeal of the law.

Policy Recommendation:

The portion of Montana's Sexual Crimes Act which makes sexual activities between consenting adults illegal should be repealed.

C. CONFIDENTIALITY AND THE "NEED TO KNOW"

Current Law:

Four Montana statutes address aspects regarding the release of information about a person's HIV status. These are the Uniform Health Care Information Act (governing what information health care providers and their employees can divulge and under what conditions), the Government Health Care Information Act (governing what information employees of health departments and other government employees can divulge and under what conditions), the Sexually Transmitted Disease statute (which describes the release of confidential information), and the AIDS Prevention Act (which speaks more specifically about the identification of subjects of HIV tests and identifies the penalty for disclosure of confidential information).

All of these laws recognize the importance of protecting personal health care information and prohibit disclosure of such information without the patient's written authorization except under certain clearly defined circumstances. Disclosure without the patient's authorization is permissible based on "need to know" and the statutes list the situations where this applies (e.g., to a person who is providing health care to the patient, for public health purposes, etc.).

Issues:

Unfortunately, there are apparent inconsistencies between the Uniform Health Care Information Act and the AIDS Prevention Act regarding the release by health care providers of the identify of a subject of an HIV-related test to others. After a recent review of these statutes, the Attorney General's Office released the following opinion on August 10, 1992.

> A health care provider may release health care information about a subject of an HIV-related test, including the identity of the subject, to a contact as defined by section 50-16-1003, MCA, without the subject's authorization, only when the health care provider "reasonably believes" that disclosure will avoid or minimize an imminent danger to the health or safety of the contact or another individual.

This interpretation is seen by some as too liberal, allowing the release of names of individuals in situations where the critics believe identification of individuals should be protected. They point to the particular sensitivity of releasing information about a person's

serostatus, given issues of discrimination and stigmatization, and argue that this interpretation cannot stand.

(It should be noted that there have been serious breaches of confidentiality in Montana. These generally occur within health care settings when many workers are involved with the care of a person with HIV/AIDS and one of the workers gets careless about whom they talk to about the patient. No breaches of confidentiality on the part of public health workers at the State or local levels are known to have occurred.)

Policy Recommendations:

Montana's statutes regarding confidentiality and the "need to know" should be clarified so that all understand that instances which permit identifying information to be released regarding an individual's HIV status are rare. MDHES shall develop policies addressing this issue and assist health professional organizations in the education of their membership.

D. HIV REPORTING REQUIREMENTS

Background:

Standard public health practice involves many strategies. One of these is the requirement for health care providers to report certain diseases and conditions to the local public health officer. Such reporting requirements serve four primary functions:

* **Understanding Disease Trends:** knowing how many people are getting a disease and what their characteristics are enables the design of rational disease control programs. (This study of the ecology of a disease is called "epidemiology".)

* **Partner Notification:** assuring that people who may have been exposed to a disease are notified, provided treatment, and given information is important to reduce transmission of infection to other persons. From a public health perspective, partner notification is especially effective if the available treatment leaves the treated individual non-infectious, thereby breaking the cycle of disease transmission. With HIV/AIDS there is no ultimate cure; so, the most important reason to notify and counsel partners of persons who are infected is to educate them about how HIV is transmitted and what they must do to protect themselves -- messages which most who have just been exposed to HIV are particularly primed to listen to.

* **Treatment Decisions:** assuring that each person with the disease receives the opportunity for prompt and proper treatment is also a reason diseases are reported.

* **Prevention of Further HIV transmission:** providing education to assist infected individuals in developing the skills necessary to protect others from infection.

Tests for HIV infection (including asymptomatic HIV infection) became widely available in 1985. Since that time forty-three states have implemented various forms of required reporting of non-AIDS HIV infection. Twenty-nine of those states require reporting of the identities of individuals with non-AIDS HIV infection (that is, all persons with positive tests for HIV antibodies).

Various professional organizations have endorsed conflicting policies on whether to recommend mandatory reporting of the identities of HIV seropositive persons to local public health authorities. For example, the American

Medical Association supports reporting while a number of state medical associations oppose it.

Proponents argue that reporting the identities of seropositive persons:

* Would improve the documentation of epidemic trends. Current reporting of only AIDS cases reflects infections that occurred 3-10 years ago. Reporting asymptomatic seropositives would provide a more accurate reflection of recent infections and trends. Including the names is necessary to avoid duplication in counting the case numbers.

* Would allow for the development and maintenance of a confidential public health "register" of people with HIV infection. Such a register could:

  a) improve the operation of HIV partner notification programs by avoiding duplication of effort on the same case (e.g., partner notification of a sex partner who was already known to be HIV seropositive and aware of his/her status);

  b) facilitate enforcement of laws prohibiting behaviors that endanger the public health by providing documentation of when a person became aware of his/her HIV infection;

  c) allow public health authorities to inform people with HIV infection about beneficial programs and treatments.

* Would not pose significant risks to the civil rights of people with HIV infection. Proponents cite the excellent public health record of maintaining the confidentiality of reports of other diseases.

* Would mean that HIV is handled like any other communicable disease. Proponents say this is how it should be -- there is no reason to treat it differently.

* Would enable the State to qualify for more federal dollars for surveillance which are available only to states which have reporting of HIV status by name.

Organizations that oppose mandatory reporting of the identities of HIV seropositive persons include the American Public Health Association, the National Academy of Sciences and the Institute of Medicine, and the American Psychiatric Association, among others.

Opponents argue that identity reporting would be counterproductive because:

* Reporting is a deterrent to voluntary HIV testing. Multiple reported studies show that the threatened implementation of reporting or lack of anonymous services can substantially reduce willingness to seek HIV counseling and testing.

* Self-selection bias in requests for voluntary HIV testing compromises the validity of extrapolating disease trends from such data. Blinded probability samples are a more reliable way of monitoring disease trends. Such sampling does not require reporting the names of people who are seropositive.

* Keeping accurate registers is very time intensive and would utilize funds which could better be spent in other ways to combat the AIDS epidemic.

* The success of partner notification programs depends on the voluntary disclosure of the identities of sex or needle-sharing partners. A registry of seropositive persons is not essential to the success of an HIV partner notification program.

Current Situation:

Montana adopted administrative rules requiring reporting of HIV seropositive test results without name in November of 1987. (Note: AIDS is reportable by name.) The report asks all those performing tests -- public and private -- to report positive test results with the name and address of the provider. For private providers submission of any more information is not required. As a condition of its contracts with the counseling/ testing/referral/partner notification sites, where anonymous HIV tests are performed, the MDHES AIDS Program requires demographic information on all those tested. A universal code for reporting HIV test results is not in use among the test sites though each site utilizes some local code so that it can assure that the right individual gets the right test results. All private labs are to submit results of all tests performed by them (but reporting by labs is not enforced and is very lax).

Approximately 50% of HIV tests are done in the state-supported counseling and testing sites and 50% in the private sector. It is estimated that approximately 90% of all HIV antibody tests are processed at the state lab. However, a new product which enables tests to be processed in a physician's office with results available within

future years.

PREVENTION PROGRAMS AND SERVICES

Counseling, Testing, Partner Notification

I. **Counseling, Testing, Referral and Partner Notification (CTRPN).** There are 11 publicly supported sites. (Note: In addition, anyone can go to a private physician or clinic for HIV counseling and testing. About half the HIV counseling and testing done in Montana to date has been performed in the publicly supported sites, and half in private sites.) The publicly supported sites offer anonymous testing. The CTRPN sites are listed below along with the geographic area each serves. It should be noted, however, that clients may use any CTRPN site they choose.

* Bridger Mountain Family Planning, Bozeman
* Cascade City-County Health Department, Great Falls
* Central Montana Family Planning, Lewistown
* Dawson County Health Department, Glendive
* Deering Community Health Clinic, Billings
* Family Services Center, Butte
* Flathead City-County Health Department, Kalispell
* Hill County Health Department, Havre
* Missoula City-County Health Department, Missoula
* Lewis and Clark City-County Health Department, Helena
* Roosevelt County Health Department, Wolf Point

Services are offered free of charge to individuals, but sites may ask for a donation. All tests are processed by Montana Public Health Laboratory (MPHL), as are X% of private tests.

Funding Source: Federal -- Centers for Disease Control, $74,749 spent in SFY1991 for operational costs of CTRPN sites including the collection and mailing of specimens, counselors and materials. In addition to the costs above, approximately $28,000 in laboratory support was provided to the MPHL.

Numbers of Tests: Because HIV tests are not reported by name or other unique identifier, it is not known how many unduplicated individuals were tested in the CTRPN sites. It is possible to report the number of tests given. The 11 sites provided approximately 4300 tests during the first 9 months of 1992.

Administration: MDHES contracts with CTRPNs for services.

Issues: Most sites are underfunded. Many supplement the federal dollars with County funding. Some use volunteers to perform the counseling in order to stretch their resources. Either greater efficiencies need to be achieved or

additional revenues procured for most sites to be able to continue at current level.

The vast proportion of tests are done for relatively low risk individuals. The CTRPN sites with the greatest proportion of high risk individuals in their test population estimates that 20-25% are high risk. The two issues here are: should lower risk persons be paid for with such scarce dollars or referred elsewhere for services; and how can more higher risk patients be attracted (some programs are moving to alternate test sites and/or alternate hours -- these strategies will likely add costs).

II. **Partner Notification Services.** This is a service available to HIV-positive individuals who would rather not inform their sex- and needle-sharing partners of their HIV status. This service is provided either by MDHES, the local CTRPN sites, or other trained local personnel.

Funding Source: CDC - HIV Prevention grant.

Number of Persons Notified: NA

Administration: County Health Departments and CTRPN sites conduct this activity with the assistance of MDHES.

Issues/Problems: All physicians in the State may not be fully aware of the importance of this service. MDHES is planning to take a more proactive approach by contacting physicians and offering assistance.

Education

I. **Health Education/Risk Reduction (HERR) Sites.** Nine sites contract with MDHES provide health education and risk reduction and outreach to minorities, students, health care providers, and the general public.

Sites include all CTRPN sites except Lewistown and Havre.

Funding Source: Federal -- CDC, $68,320 in 1991 for salaries, education materials, and travel within their regions.

Numbers of Persons Served: 16,500 Montanans in 1991.

Administration: MDHES contracts with HERRs for services. HERRs subcontract 10 to 15% of their grant to a local AIDS community-based organizations of their choice.

Issues/Problems: All sites are underfunded to do the job they need to do.

II. **Preventive Health Block Grants.** The 1991 Montana legislature earmarked a portion of federal block grant funding for HIV/AIDS education. Approximately $425 for counties without an HERR site was earmarked for 1991 and a similar amount is anticipated in 1992.

Funding Source: Preventive Health Services Block Grants (Federal).

Numbers of persons served: 14,145 during state fiscal year 1991.

Administration: MDHES distributed funding primarily by County Health Departments.

Issues/Problems: Funds are limited.

III. **Montana Migrant Health Project (MMHP).** The MMHP provides bilingual outreach and HIV education to Hispanic migrant farm workers in Montana.

Funding Source: Federal -- CDC, $6,000 in 1991, $4000 in 1992.

Numbers of Persons Served: 1400 individuals in 1991.
2100 individuals in 1992.

Administration: MDHES contracts with MMHP for services.

Issues/Problem: Funding is inadequate to do this challenging and difficult job. But what is the right amount? Where might it be found?

IV. **The Little Shell Tribe.** The Little Shell Tribe provides outreach and education to Montana's urban American Indian population. Contract calls for prevention/education needs assessment, train the trainers program with tribally controlled colleges and Native American studies programs, coordination of Montana Minority Task Force, working with Native Americans whose behavior puts them at high risk for HIV/AIDS.

Funding Source: Federal -- CDC, $40,000 in 1991.

Numbers of Persons Served: 360 American Indians directly and another 1000 through television programming.

Issues: This and other programs aimed at HIV/AIDS education/prevention for minority populations should be coordinated through Montana Minority Task Force.

V. **Out in Montana/Montana Gay Health Project and Criticare.** OIM/MGHP provide education and outreach to gay and bisexual men. Safer sex education, homophobia education, hotline geared to gays, networking with community based organizations and health departments on how to include gay men, are among its activities.

Funding Source: Federal -- CDC, $38,000 in 1991 to OIM/MGHP.

CDC, $27,000 in 1992 to Criticare

Numbers of Persons Served: 620 persons in 1991.

Issues: Outreach to gays and bisexuals needs to be expanded.

VI. **Office of Public Instruction (OPI).** OPI is responsible for the developing educational materials including an HIV curriculum, designed to provide guidance to local school districts, and to train instructors in the implementation of the curriculum.

Funding Source: Federal -- CDC, $235,000 in 1991.

Numbers of Students Served:

Administration: Grant direct to OPI.

Issues/Problems: OPI AIDS curriculum and training-the-trainers program are perceived to be very good. Program needs to be closely linked with what MDHES AIDS Program is doing in education.

VII. **Indian Health Services (IHS).** With respect to HIV prevention and education, the IHS was allocated funds for prevention and education efforts targeting the 30,000 American Indians living on Montana's seven reservations. Approximately $42,000 went for this purpose between October 1, 1990, and September 30, 1991. A separate allocation was made to target prevention and education of the approximately 17,000 American Indians not residing on reservations. $41,000 was granted for this purpose during the same time period.

During 1992 the Regional Office will have $135,000 available for AIDS education/prevention activities on the reservations and $30,000 for those not residing on reservations.

Funding Source: IHS

Issues/Problems: IHS needs to coordinate closely with other entities and engage in joint planning for program development.

VIII. **Montana Department of Health and Environmental Sciences.** The MDHES AIDS Program, in addition to contracting for the above named services, carries out a variety of educational activities including writing and distributing pamphlets, developing and managing public information campaigns, and operating a statewide AIDS hotline.

II. **Northwest Area Training Center.** This center is a regional education and training center program serving health care professionals in Washington, Idaho, Montana, Alaska and Oregon. The mission is to provide formal training in the clinical, legal, ethical, and psychosocial aspects of HIV infections to primary care providers.

OFFICE OF PUBLIC INSTRUCTION
HIV/AIDS EDUCATION ACTIVITIES

Montana AIDS Education Program

The Montana Office of Public Instruction receives funds from the Centers for Disease Control for the Montana AIDS Education Program. The program's general objectives are aimed at:

* increasing the number of schools that provide effective HIV/AIDS education (including in grades 11 and 12);
* increasing the number of junior high and senior high students (including students in grades 11 and 12) who receive education about how to avoid becoming infected with HIV;
* increasing the number of schools that integrate HIV/AIDS education within a more comprehensive health education program;
* providing assistance to agencies that subsequently will implement HIV/AIDS education programs for minority youth, youth in high-risk situations, and/or youth with special education needs;
* providing updated training/educational forums to universities and colleges that offer degrees in teacher education in order that these units of higher education can provide effective HIV/AIDS education to teacher education candidates;
* providing and/or arranging training and technical assistance to teachers and other school personnel in planning, implementing and evaluating comprehensive school health education;
* continuing coalition involvement with agencies advocating comprehensive school health education;
* conducting knowledge, attitude, belief and behavior surveillance of Montana adolescents, and determining the availability and extent of HIV prevention education by surveying administrators in Montana schools; and
* conducting evaluation activities to provide the information necessary to document program progress and to improve program activities.

OPI's activities reflect a continued coordinated effort between numerous educational and state agencies that deal with school-age children in and out of school.

Under the CDC-funded program, OPI has developed and distributed to all schools curriculum planning guidelines and model HIV/AIDS curricula for elementary, junior high, and senior high classes. They have developed and distributed to all schools model policies for schools to use or adapt concerning communicable diseases (including HIV) and students and staffs. OPI has also trained teachers who themselves have trained other teachers and have

taught HIV/AIDS education. Further, OPI carries out knowledge assessment activities.

In the curriculum planning guidelines, material from the CDC's Morbidity and Mortality Weekly Report is quoted as follows:

> Schools should allocate sufficient personnel time and resources to assure that policies and programs are developed and implemented with appropriate community involvement, curricula are well-planned and sequential, teachers are well-trained, and up-to-date teaching methods and materials about AIDS are available. In addition, it is crucial that sufficient classroom time be provided at **each** grade level to assure that students acquire essential knowledge appropriate for that grade level, and have time to ask questions and discuss issues raised by the information presented.

Further, in its model policies, OPI makes the following recommendation (among others):

> School districts will provide an ongoing educational program about HIV for students, for staff members and other employees, and for the community. The educational program will include: current scientific evidence about HIV and its transmission, school district policy on communicable diseases such as HIV infection, other resources students/staff/community members can go to for more information, and procedures to prevent the spread of all communicable diseases at school.
>
> Funding Source: Federal -- Centers for Disease Control, $329,000 in 1991.
>
> Administration: Office of Public Instruction

STATEWIDE PROGRAMS AND SERVICES FOR PERSONS LIVING WITH HIV/AIDS

I. **AIDS Drug Reimbursement Program (ADRP).** This program provides Zidovudine (AZT), Videx (ddI), Hivid (ddC) and pentamidine to qualified individuals at no cost. Though individuals must meet medical and financial eligibility criteria to qualify for the program, the aim of the program is to assure that those who need the covered drugs and who would suffer financial hardship without the drug subsidy, are able to get them. As alternative drugs are approved, MDHES will investigate the costs and the possible demand and consider whether to include these drugs on the program. The ADRP program is in its fourth year.

Funding Source: Federal -- Health Resources and Services Administration (HRSA) through Ryan White Title II. In SFY91, $23,205 from HRSA and $2,500 from Title II. In FY92 (4/1/92-3/31/92), $47,000 of Title II funds were allocated.

Numbers of Persons Served: 29 in 1991; estimate 45 in 1992.

Administration: Administered by MDHES AIDS Program; drugs obtained from 4 regional contract pharmacies.

Issues: Physicians treating persons with HIV/AIDS are very pleased with this program. It is likely federal funding will continue over the next 3 years.

II. **Continuum of Health Insurance Coverage.** This program allows eligible individuals to continue their private health insurance by having the program pay for all or part of a person's premiums. Eligibility requirements include financial and medical criteria.

Funding Source: Federal -- Title II with $5000 in FY1991 with approximately $3000 carried over to FY1992 plus $3000 new Title II funds.

Numbers of Persons Served. 2 served during FY91 and an estimated 3-7 clients in FY92.

Administration. MDHES developed eligibility criteria, publicizes the program, refers clients to the Department of Social and Rehabilitative Services (SRS) to administer this program along with a similar program they administer for Medicaid recipients. SRS accepts referrals, determines eligibility using MDHES guidelines, collects information on the insurance policies of potential applicants and issues payments.

Issues: Funding secure only if Title II renewed. Program

little used to date -- may need to be marketed as some who should know about it do not.

III. **Early Intervention Program.** This program provides CD4 testing and a medical evaluation for HIV positive individuals as well as educational sessions with an early intervention counselor. Program sites function in conjunction with the Counseling, Testing, Referral and Partner Notification sites through the Cascade City-County Health Department in Great Falls, Deering Community Health Clinic in Billings, Flathead City-County Health Department in Kalispell, Hill County Health Department in Havre, Lewis and Clark City-County Health Department in Helena, and Missoula City-County Health Department in Missoula.

Funding Source: CDC - HIV Prevention grant.
HRSA- Ryan White Title II.

Numbers of Persons Served: Approximately 35 clients have been served during the first three quarters on 1992.

Administration: MDHES contracts with county health departments to provide this service.

Issues: None noted.

IV. **HIV Care Consortia.** Regional HIV Care Consortia were established in 1991 in response to the Ryan White federal initiative. The aim of the consortia is to plan, develop and deliver comprehensive outpatient health and support services to meet the identified needs of individuals and families with HIV disease within designated geographic areas. Services paid for by the consortia are determined locally based on client need. In 1991 these services were provided: case management, medical/ nursing/dental, mental health, benefits advocacy, and medications, and early intervention services.

The five consortia in the state serve areas which approximate the Governor's planning regions. (See attached map). Regions I and III joined to form one consortium while two consortia emerged in Region V. The consortium that developed in Region IV chose not to cover all counties in the region, leaving 5 counties which are not active participants in a consortium (though residents from these 5 counties could seek services from existing consortia).

Funding Source: Federal -- Ryan White Title II, FY1991 allocation of $60,000. FY1992 allocation of $45,000 with some carryover from FY1991.

Numbers of Persons Served: 17 as of January 24, 1992.

Estimate 48-56 in 1992.

Administration: In 1992, reimbursement for services to be handled centrally by MDHES (except for Yellowstone which may remain independent and handle their own funds and administration). Consortia will determine client need and authorize service provision.

Issues: Services may differ from region to region due to decisions made at the local level regarding services offered, eligibility, etc.

V. **Medicaid.** The Medicaid program pays providers for health services for persons who qualify based on income eligibility. A number of persons with HIV/AIDS have utilized Medicaid reimbursement for needed services.

Funding Source: Federal and State -- HCFA and Montana State General Funds. In SFY1991 $477,505 was spent on HIV related illnesses. Approximately 30%, or $143,252, was contributed by Montana, the remaining 70%, or $334,253, came from federal sources. This was a significant increase over the costs reported for SFY90 when an estimated $213,000, with $64,000 contributed by Montana, was spent for HIV-related services.

Numbers of Persons Served. 26 clients were served during the first 6 months of SFY91, and 32 clients served during the second have of that year.

Administration. SRS administers the state Medicaid program.

Issues: Many who are eligible have not accessed Medicaid because they do not understand, or are not willing to deal with, the process required to qualify. Also, some who believe they should be eligible are not deemed to be so because their physicians have not indicated that they are functionally unable to work (which would qualify them for SSI and thereby make them eligible for Medicaid).

VI. **Department of Corrections and Human Services (CHS).** CHS provides health care and support services for people in 7 institutional and correctional settings in Montana.

Funding Source: State (?). HIV-related services ranged from hospitalization to diagnostics and prescription costs. Estimated costs from July 1, 1990, through June 30, 1991, were approximately $30,000. Cost estimates from SFY90 were $73,000, or more than twice the 1991 costs.

Numbers of Persons Served. 8 clients were served in period July 1990 through June 1991.

Issues: Once persons are released from prison, including to a pre-release center, no one picks up their medical care costs. For several persons with HIV/AIDS, this has created a major problem.

VII. **Indian Health Services (IHS).** The IHS is responsible for providing health care for American Indians residing in Montana. This is accomplished through health services which are available on the State's 7 reservations and through contract services with 3 urban outpatient clinics.

Funding Source: Federal -- IHS. The IHS spent $3,600 for AZT for 4 individuals from Oct 1, 90, through Sept 30. 1991.

Numbers of Persons Served.

Administration. IHS Regional Office, Billings, oversees and allocates funds.

Issues: No issues peculiar to HIV/AIDS and health services -- the usual issues related to urban Indians accessing services if they are not enrolled members of a tribe and, for those who are, getting to and from IHS facilities for services is sometimes a problem.

AIDS Planning Advisory Council

Teen Representatives

Sasha Davies
Sonya Buchholtz
Jeremy Glenn
of Missoula

Health Department Representatives

Dennis Klukan
Flathead City-County Health Dept.
723 5th Avenue East
Kalispell, Montana 59901

Bob Johnson
Lewis and Clark Co. Health Dept.
316 North Park
Helena, Montana 59624

June Luptak
Deering Community Health Center
123 South 27th
Billings, Montana 59101

Native American Representative

Tony Plummer
Whitefish, Montana 59937

Office of Public Instruction Representative

Rick Chiotti
Office of Public Instruction
Helena, Montana 59620

Out in Montana/Montana Gay Health Project Representative

Danny Mills
Helena, Montana 59601

Medicaid Representative

Kay Marshall
Medicaid Utilization Review
SRS Building
Helena, Montana 59620

Community Based Organization Representative

David Herrera
Yellowstone AIDS Project
Billings, Montana 59101

Montana Medical Association Representative

David Calhoun, M.D.
Billings, Montana 59107